Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM/1 perphys C862 12/15/06 WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IRWIN J. **JOHNSON** Month Day **Physician** Year 2145 PM 7 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marylann Medral Cente more 0 alti If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☑ M 2 □ F 50 Director 03 56 216-62-8690 05MD Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show at ral", or items 23a or 28a-f sh Examiner must be notified Director MD Baltimore X Yes 2 No NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 U.S.A. 431 Oxford Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □Yes 2 □
If Yes, Give
Year or Dates: Never Married 2 ☐ Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black 'natural", Completed h and Mental Hygiene.
7 is marked other than "natuitraumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Longshoreman Ship Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be Lewis Johnson I Margaret Falls ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: If Item 27 is any injury or other trauonce. Margaret Wade-Sister 1910 Penrose Ave, Baltimore, Md 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 12/18/06 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XUnknown cate has been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy perform Endocardi certificate 1□ Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 papatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Watural (Month, Day Year) To the nospinal within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 TAccident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title-of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) 6+1 and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore 10# 31. Date filed (Month, E Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Physician /Medical Examiner Records, certificate Vital Johnson

Physician/Medical Examiner burial-tran ed by the a s been signed b should be deta Completed by page 2 s Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifics stely filled in by the funeral director, p. Be

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show

altimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

of Health and Mental Item 27 is marked o

permit. Pages 1
Department of H
Important: If Iter
any Injury or ott

To the Hospital of within 24 hours af To the Funeral D completely State Registrar

Medical Certification: To

4 ☐ Homicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

P18617 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAGAT Beltimore MD 2/22

December of 2006

31. Date filed (Month, D. 32" Registrar's Signature Year.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12 3:07pm Louise Marie Januk Dec. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 602 Fuselage Avenue Essex Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth 8. Date of Birth Month, Day, Year, 1918 Soundry April 11,1918 Maryland **Funeral** Months 1 □ M 2 🖵 F 88 214-20-3925 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "neturel", or items 23a or 28a-f ehow The Medical Examiner must be notified at Baltimore MD Essex Director 1 Yes 2 No death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 Fuselage Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiane. Machine Operator American Can 8th traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fit if Health and Mental H Item 27 is marked ott Be Lois Schubel Antoinette Pinkus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Heatterich /daughter 602 Fuselage Avenue Baltimore MD 21221 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 Removal from State pernit. Page Department of Importent: if any njury or once. OAk LAwn Cemetery 12/16/06 Baltimore MD 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto.MD 21. Signature of Funeral Service License Ð elle Connelly Funeral Home of Essex 21221 23a. Part . Enter the disease of conflications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cononary A

Due to (or as a consequence of): ANTER disease or condition resulting in death) 5413 /Medical Examiner 2 DIABETES CE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of): Examiner ¥ attending physician and for use as the burial-transit The law requires that the death certificate be executed >10425 ITY ENTENSION resulting in death) Last Due to ras a consequence of): Minn by Physician/Medical citronic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) o. 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DEMENIJA been si should I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 his certificate h I director, page 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Matural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours aftar deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suícide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 University and manner as stated, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0028812 12/14/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROIAD 780 OLK 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 5 2006 Registrar

DHMH 17 Rev 1/2001

06-09463 William John Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	ate of	Death		Re	eg. No.	
Physicia	an/	Decedent's Name (First, Middle,Las	it)					2. Date of Deat Month	th	3. Time of Death
બ્લાંcal Exami	ner	William		Johr				December		2040 hrs
	÷	4a. Facility Name (if not institution, give 2019 Cliftwood Avenue	re street and number)		4t	Baltimore	r Location of	Death .	4c. County of D NA	
Funeral		Social Security Number 6. S.	9х 7. А дө (!n yrs. last birt	hday) .	If Under 1 Ye	-		i ir	l. Birthplace (State or oreign
Director	i	215-34-8964	ĞM 2□F	69	Yrs.	Months Da	ys Hours	Min. 12-1	10–1937	Country) Va.
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Aaryland 28s-f show 3 af once.	ector		NA			imore				
e Mar or 28s	Direc	10e. Street and Number				10f. Zip Code	2		0g. Citizen of What	Country?
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eath w	Funeral	1 Never Married 2 Married	Armed Forces?	7				Puerto Rican, etc.)	White, e	
Rer de l'', or		3 Widowed 4 X Divorced	If Yes, Give Year	No	1 🗆 🤄	Yes 2 X N	n specify:		Specify:	Black
Surs a	yc b	15. Decedent's Education (Specify of	Lor Dates: nly highest grade compl		Decedent's	s Usual Occup	ation (Give kir	nd of work done	16b. Kind of Busin	
6 1.72 ் 8ள "ந	eted	Elementary/Secondary (0-12)	College (1-4 or 5+) [_	st of working lif		se retired)		~ · · · · ·
5-0036 lied within 7 Flygiene. I other than	Comp	6th grade			Steel	Worker				hem Steel
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21218 build be filis Mertal B marked ic event, t	70 B	19a. Informant's Name/Relationship (o. Mailing .	Address (Stre		er or Rural Route Num		-
스 용 된 호 프	- 1	William E. John	s, Jr. So		1358			enue, Balt:		
re, Mi I and 2 s Health at Fitem 27		20a. Method of Disposition			of Disposit	ion (Name of c	emetery,	Date	20c. Location - Ci	ty or Town, State
MOF Pages lent of int: If		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify	_	1	•	t Cem.		12-15-06	Baltim	ore, Md.
Baltimore, permit. Pages I as Department of He Important: If ite		21. Signature of Funeral Service Licer				me and Addres		March F	.H. East	
		19 Ladys	Warren	2				Ave., Balt		d. 21202
Physician VMedical		23a. Part I. Enter the disease, or comp failure. List only one cause on e		e death. Do no	ot enter the	e mode of dying	, such as car	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Chset and
xaminer		Immediate Cause (Final disease a or condition resulting in death)	Atherosclerotic C		lar Dise	ase				Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):						-
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executed in and il - transit		d								
	/Medical	UNPENDED	AMENDED							
	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnancy				1	23d. Date of del	*
OX 68 eath certif	cian	past 12 months?	1 Live birth 4 Pregnant at tir	ne of death		al death 3	Ectopic p	regnancy	Month	Day Year
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Rec The la cate ha	mo								rmed? dear 2 ✓ No 1	th? Yes 2 No
Vital Rec ysician: The l his certificate I director, page	Be C	25. Was case referred to medical examiner?				26.Plac	`	heck only one)		
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n of V ding Ph		27. Manner of Death 1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	r) 28b.	Time of Inj		ury at Wcrk? Yes 2 N		now injury occurred	
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Division sphal or Attendi ours after death. reral Director: A	Certification:	3 Suicide 6 Could not determine		y - At nome, ta	am, street	, lactory, office	building, etc.	or Town, S		or Rural Route Number, City
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To the Hos within 24 h To the Fur completely	edical	oro) 2 Medical Examine	r:On the basis of exami							
F ≥ 5 8	Me	29b. Signature and title of certifier	and manner stated.			29c. Licer	se number	200	29d. Date signed	(Month, Day, Year)
		16/11/	V. TO		a	0.0	.M.E.		December 12	, 2006
ソカー		30. Name and address of person who	1/	ath (Item 23a)	<i>V</i>)			<i>2</i> -	L	
		Theodore M. King, Jr., MI	- 43		iner 1	I11 Penn S	treet, Balti	more, MD 21201		
S Regis	tate	31. Date filed (Morte Pro, Year) 5	006 32. Registrar's	Signature	Soa	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier@ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death РМ December 9, 3:30 2006 Esther Sara Ann Jackson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 🖾 F 93 577-20-3600 December 5, 1913 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Virginia Fairfax Springfield 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22152 United States 6706 Deland Drive 14 Bace - American Indian anic Origin? (Specify Yes or No-

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Iteme 23a or 28e-f ehow eny Injury or other treumatic event, the Medical Examinar must ke notified at once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a, State

Director

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

been signed by the ettending physicien and should be detached for use as the burial-transit

within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 o the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

70	0700 Detaile Dilve	E		44	1)2		OHILCU	56	accs
To Be Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 図 No	. 13. Wa	as Decedent of F res, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)			erican Indian, te, etc.
l by F	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	10	∃Yes 2⊠No	Specify:		Specify:	W	hite
etec	15. Decedent's Ed (Specify only highest gra		16a. Deceder	nt's Usual Occup nd of work done	pation during most of wi d)	orking	16b. Kind of Bus	siness	/Industry
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Be	Clyde Llewelyn Fo					r Swann			
۵	19a, Informant's Name/Relationship (1		10h Mailian	Address (Ctrass		lural Route Number,	City or Tourn	State	Zin Codel
	Mary Jackson Cla		•			t Park, M			
			ce of Disposit	-	, darree		20c. Location - (
1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	netery, crema	itory or other pla	ce) Dec	ember		•	
	4 ☐ Donation 5 ☐ Other (Specify	. Pu	ontgome	rium Inc		2000			Maryland
	21. Signature of Funeral Service Licen		22. Bet	Name and Addre hesda-C	ess of FacilityRo hevy Cha Maryland	bert A. P se Inc. 7 20814	umphrey 557 Wis	Fu	neral Home/ nsin Avenue
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cation; To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions of	contributing to death but not resul	ting in the und	leriving cause gr	ven in Part I.	23e. Did tot	acco use contr	ibute t	to the cause of death?
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0 8	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient	3□ DOA Ot	her: 4 Nursing	Home 5 ☐ Reside	ence 6 □Othe	er (Spe	ecify)
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Ę	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk?]Yes 2∐No				
	3 ☐ Suicide 6 ☐ Could not b	e 29a Place of Injury - At hor	ne farm stree	et factory office		28f. Location (St	reet and Number	ar or F	Rural Route Number,
Medical Certifi	4 Homicide determined	building, etc. (Specify,		, ,		City or Town	n, State)		
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dica		miner: On the basis of examinati and manner stated.	on and/or inve	estigation, in my	opinion, death oc	curred at the time, d	ate and place, a	ind du	e to the cause(s)
Me	29b. Signature and title of certifier	and the thought		29c. Licen	se number	2	9d. Date signed	(Mon	nth, Day, Year)
	1 - 11			D18	726				11, 2006
	you sall	177			•				
	30. Name and address of person who				Dadre	r_10 Ω1∽	ou Ma-	₁₇ 7 -	and 20832
	Arthur Schoengol	a, M.D. IOIII	rrince	LUTTID	nitine,	I-IO, OIN	ey, mar	у⊥∂	111U ZUOJZ

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1

5 2006

32. Registrar's Signature

06-09399 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Erik Nelson Joyce State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registra 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Medical Examine Erik Nelson Joyce Month Day December 9, 2006 2352 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number **Funeral** 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 241-04-4979 Months Days Hours 49 $_{1}[X]_{M}$ Aug. 19, 1957 Country Alabama Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 23a or 28a-f show notified at once. Maryland Montgomery Pages I and 2 should be filed within 72 hours after death with the Maryland Yes 2 X No Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 11403 Stonewood Lane 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black Armed Forces? Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Yes 2 X No Widowed Divorced If Yes, Give Year Yes 2 X No specify: White ģ Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Photo Lab nent of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert William Joyce, Jr. Be Marilyn Russell 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Deborah P. Joyce/Wife 11403 Stonewood Lane, Rockville, Maryland 20852 20a Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date Dec. 13, Burial 2 X Cremation 3 Removal from State crematory or other place) Montgomery tant: Donation 5 Other Specify Crematorium, Inc. | 2006 | Bethesda-Chevy | Robert A.. Pumphrey Funeral Home/Chase 10 Inc. Bethesda, Maryland 21 Signature of Funeral Service Licensee M00198 7557 Wisconsin Ave. Bethesda, MD 20
23a. Part I Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line /Medical Between Onset and Immediate Cause (Final disease Cardiac arrythmia ₹xaminer Death or condition resulting in death) Due to (or as a consequence of) Cardiomegaly associated with mitral valve prolapse Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed attending physician and or use as the burial - tran sician/Medical X UNPENDED **AMENDED** #23a-b.27.perME Box 68760 23c. If yes, outcome of pregr 23d. Date of delivery 23b. Was decedent pregnant in the Live birth past 12 months? Fetal death 3 Ectopic pregnancy Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ Records, P. 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 1 V Yes Residence 6 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred X Natural Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certific 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E December 10, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

BORNES S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2006 40007 06-09427 Ronald E. Johnson 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death cal Examiner 3. Time of Death Ronald E. Johnson Month 2030 hrs December 10, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore **Funeral** 5. Social Security Number If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Age (In vrs. last birthday Director 214 66 1147 Months Hours 1 X M oreian 2 53 09/01/1953 Country) Mary land Usual Residence of Decedent BUS 10b. County 10a State 10c. City, Town or Location 10d Inside City Limits Maryland N/A or 28a-f show items 23a or 28a-f shovust be notified at once. Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 E. Patapsco Avenue 21225 U.S. Funeral 12. Was Decedent Ever in U.S. event, the Medical Examiner must be 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married 2 Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No 10 Yes 3 X Widowed Divorced If Yes, Give Year "natural". Yes 2 X No specify. \$ Specify: White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 College (1-4 or 5+) other than timore, MD 21215-0036 9th Truck Driver of Health and Mental Hygiene Lumber Company 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) marked Clifford Johnson Pauline Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Johnson / Daughter 11 Humming Bird Court Baltimore, Maryland 21227 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place Donation 5 Other Specify Meadowridge Mem. Park 12/15/2006 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility ²² Name and Address of Facility Gonce Funeral Service, P.A 4001 Ritchie Highway Baltimore, Maryland 21225 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Part I. Enter the disease failure. List only one case on each line. Thrombosis, Right coronary artery due to plaque rupture and Approximate Interval **/Medical** Between Onset and Immediate Cause (Final disease Éxaminer severe coronary atherosclerosis Death or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical attending physician are as the burial -X UNPENDED AMENDED certificate be #23a,27,perME Box 68760 g863. 1/10/07 TT IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth past 12 months? 3 Ectopic pregnancy Fetal death 2 Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? 2 مَ 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed 24a. Was an 24b Were autopsy findings available has 2 s autopsy prior to completion of cause of performed? certificate ✓ Yes 2 1 🗸 Yes 2 No 25 Was case referred to medica Hospital or Attending Physician; 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ 1 Yes Inpatient 2 V ER/Outpatient 3 No DOA Nursing Home 5 Residence 6 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred the Pending 1 Yes 2 No Certificat Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 28f. Location (Street and Number or Rural Route Number, City To the Funeral determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 31. Date filed (Month, Pay

2008

and manner stated

Market St. 10

111 Penn Street, Baltimore, MD 21201 32./Registrar's Signature THE SALE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

29d Date signed (Month, Day Year)

December 11, 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** 3:30 PM Arthur Albert Keen 2006 Dec. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Heritage Meridian Center Dundalk Baltimore If Under 1 Year II Under 24 Hrs.
Wonths Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 22,1926 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 150 M 2□ F 212-22-1692 80 Maryland Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Itama 23a or 28e-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 104 German Hill Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is 1 end 2 should be filed within of Health and Mental Hygiene. Itam 27 Ie markad other than Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Con Sel Company 7 Years other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elsie Culbertson Arthur A. Keen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Evelyn M. Keen (Wife) 104 German Hill Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Peges 1 permit. Peges
Depertment of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 12/14/2006 Baltimore, Maryland 21. Signatyre Funeral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final, ASPIRATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy o in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be deteched 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nknown peen 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No within 24 hours after death.

To the Funaral Diractor: After this certifice completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 210 No Certification: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Δ)		30. Name and address of person who completed cause of	+ Balt	Print)	MD.	21231	,		
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7	Physici		1. Decedent's Name (First, Middle, Last) JEROME A. KENNEDY			2. Date of Dea	ath Day Yes TR 7, 2006	3. Time of Death 9:15PM M
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death	DECEMBE	4c. County of D	
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birt	h 91	Birthplace (State or Foreign Country)
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	w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation				10d. Inside City Limits
	/aryla	5	Maryland Prince George's Brandyw					1 ☐ Yes 2 🛣 No
	the A	Directo	10e. Street and Number	10f. Zip Code			10g. Citizen of What	
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7	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-40r 5+)				What is a	
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ñ	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any injury or other traumatic er once.	16 P						ton, MD 20735
	11.69		23a Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.					Approximate Interval Between
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	To the Hospital or Attending Physician: The law requires that the de within 45 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached.	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License				
			All Aller to				9d. Date signed (Mo	
	9+1		my www.as	MD# 2	U439		DECEMBER 1	12, 2006
11	0'		30. Name and address of person who completed cause of death (Item 23a) (Type, F ANTHONY G. ARCENAS, M.D., VAMC, 50 IR	1	EET NW. W	ASHTNGT	ON.DC 2042	22/688
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature		1		2.,,20 2072	, 000
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JNK		1- For State	tate of Mary	iaiiu /	Depaπme C <i>ertifica</i>			and	wen.	ıaı Hy	_	Dog N	200	6	400
Physicia		Registrar 1. Decedent's Name (First, Mide	dle,Last)							2	2. Date of De			3 Tim	e of Death
cal Exami	ner	Anthony	W. Ke	enne	dy	_					Month Decemb	er 10, 20	006 Year	07	27 hrs
		4a. Facility Name (if not institution 3610 Cpttage Avenue		number)		4	b. City, Tow Baltimp		ocation o	of Death		4c. (County of Dea	ath	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last birtl	nday)	If Under		If Unde	er 24Hrs.	8 Date of E	Birth (MM/D	D/YYYY) 9. E	Birthplace	(State or
Director		UNK	1 X M 2 F		37	Yrs.	Months	Days	Hours	Min	06/2	3/19	69 For	eignMa] Country)	ryland
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d now any e.				ľ											Yes 2
arylan 8a-f sł at onc	Director	MD • 10e. Street and Number	·		Ba_	<u>ltim</u>	ore 10f. Zip Co	ode				10g. Citize	en of What Co		
permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Öİ	3047 Spauldi	ng Ave.				2	121	5			II C	70		
t be no	unera	11. Marital Status	12. Was D	ecedent E	ver in U.S.			of Hisp	anic Orig		cify Yes or N	lo- 1	4. Race - Am White, etc.	erican Ind	an, Black,
or its	ᄣᅵ	A	Married Armed 1 Yes ivorced If Yes, Give Y	2	X No					, r dono r	10411, 010.7		pecify: Bl	a ak	
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al Hyg	C	17 Father's Name (First, Middle						18			First, Middle		urname)		
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permit Pages I ar Department of Her Important: If ite injury or other tr	1	21. Signature of Funeral Service	e acensee										C. Jo		
ysician		23a. Part I. Enter the disease, of failure. List only one cause		t caused th	e death. Do no	t enter the	e mode of c	dying, s	uch as c	ardiac or r	respiratory a	rrest, shock	k, or heart	Appr	oximate Inte
Medical xaminer		Immediate Cause (Final diseas	77 .	and c	ocaine ii	ntoxic	ation							Betw	veen Onset a Death
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e death certificate be the attending physic ed for use as the bun	icia	past 12 months?	4 Pre		ne of death 5	=	er (Specify		Letopic	pregnan	-y	- [] "	NONLIT	Day	I ear
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Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been sitely filled in by the funeral director, page 2 should be	Certification	3 Suicide 6 X Cou	uld not be ermined (Specif		nd in ya		, ractory, or	11100 00	ilding, cu	B	or Town,	State) 36	10 Cotta	age Av	enue
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5 1 8 1	Me	29b. Signature and title of certif		stateu.			29c. L	icense	number			29d. Da	ate signed (N	onth, Day	r, Year)
		You ho	nica-P	alli	des			D.C.M	l.E.			Dece	mber 10,	2006	
		30. Name and address of person Patricia Arpnica-Polla			ath (Item 23a) edical Exam	iner	111 Pen	n Stre	et. Ra	Itimore	MD 212	01			
St	ate	31. Date filed (Month Dev., Year			Signature			5	Wa						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

illiothy Kramer		1- For State Registrar	ate or iviaryiano	-	ficate of De		iu ivientai i		teg. No 21	205	1.001
Physicia		Decedent's Name (First, Middle	,Last)					2. Date of Dea	ath 5-		Time of Death
Medical Examin		Timothy Alexa	ander Krame	r				Month Decembe			1745 hrs
		4a. Facility Name (if not institution	, give street and number)			-	or Location of Deat	h	4c. County o		
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Funeral Director		497-68-4292	6. Sex 7. Ag	e (In yrs. last		Under 1 Ye onths Da		1.	24,1956	Foreign	Mington
any	ŀ	Usual Residence of Decedent 10a, State 10b. County		10c. City, To	own or Location						Od. Inside City Limits
and show	5	Texas Bra	zos		College	Stat	ion				Yes 2 No
Maryli 28a-f	Director	10e. Street and Number		-	10f	. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen of Wh	at Country	?
3a or	اق	716 Plum Hollo	w Drive			778	345		United S	tates	5
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Feath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Ma	12. Was Decedent Armed Forces?				lispanic Origin? (S an, Mexican, Puert		14. Race White		n Indian, Black,
fter de		3 Widowed 4 X Dive	orced If Yes, Give Year	X No	1 Yes	2 X N	o specify:		Specify:	Whi	te
ours a	d by	15. Decedent's Education (Spec	or Dates: cify only highest grade con	npleted) 1			ation (Give kind of e. DO NOT use re		16b. Kind of Bus	siness/Indi	ustry
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filled v		17. Father's Name (First, Middle, Donald Elvin K	,					e (First, Middle, Elva D	Maiden Surname)		
12. Id be Aenta narke	To Be	19a. Informant's Name/Relationsl		_	19b Mailing Add	ress (Stre			mber, City or Town	State Zi	n Code)
MD 21215-0036 and 2 should be filed within 7 lith and Mental Hygiene. In 77 is marked other than aumatic event, the Medical		Kent Kramer ,		ì	636 Lake	e Isla	and Drive	, Canyo	n Lake,	Texas	78133
re, leg land		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from St	20b. Pla	ace of Disposition ematory or other p	(Name of c lace)	emetery,	Date	20c. Location -		
Baltimore, permit. Pages I an Department of Hee Important: If itel	Į	4 Donation 5 Other Sp	ecify:		pton Cer				6 Hugoto		ansas
Balt permit Depart Impor injury	- 1	21. Signature of Funeral Service	Licensee MO11	13					neral Ho , Kansas		31
Physician	\dashv	23a. Part I. Enter the disease, or	complications that caused	the death. D	o not enter the me	ode of dying	g, such as cardiac	or respiratory ar	rest, shock, or hea	irt .	Approximate Interval
/Medical	ı d	failure. List only one cause	on each line. a. Multiple Injuries								Between Onset and Death
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8760 ificate b ig physic	Ě	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcome 1 Live birth	me of pregna	ancy 2 Fetal de	eath 3	Ectopic pregr	nancy	23d. Date of Month	deli ve ry Day	Year
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Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detaed.	Certification:	27. Manner of Death 1 Natural 5 Pend	28a. Date of Injudenth, Day, Month, Day, Opec 9, 2006		28b. Time of Injury 1738 hrs		jury at Work?] Yes 2 ✔ No	Plane cras	how injury occurre	ea .	
iSiC r Atte er dea irecto	ficat	. —	stigation 28e. Place of Ir	njury - At hon	ne, farm, street, fa	ctory, office	building, etc			er or Rural	Route Number, City
Div	e E		d not be (Specify) Ra	vine near	airport			Lee Airport, I	State) Edgewater, MD		
e Hosp n 24 hoi e Fune letely fi	SalC	29a Certifier 1 Certifying Pl	nysician: To the best of m								ouso(s)
To th withir To th	Medical	2 🔻	miner:On the basis of exa and manner stated		Jor Investigation,	,		at the time, date			
	Σ	29b Signature and title of certified					nse number C.M.E.		29d. Date signe December		
		Joish 3	eef me)		0.0	,,ıvı. ∟. 	-	December		
10	Ш	30. Name and address of person Tasha Greenberg MD		·		nn Street	t, Baltimore, M	ID 21201			
\ S	ate	31. Date filed (Month, Day, Year)	2006 32 Registra	ar's Signature	1		., =				
Regis		pro T a	2000	The state of							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Albert G. Kowalewski 11:10 P.M December 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 13, 1929 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 X M 2 □ F 77 216 24 9712 Yrs Director Mary land Usual Residence of Decedent 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at N/A Baltimore Maryland 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 4002 - Fifth Street 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Union Official Elementary/Secondary (0-12) 8th College (1-4or 5+) Longshoreman I.L.A. Local 1355 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be is marked of Albert Kowalewski Tillie Kupidlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 4002 - Fifth Street Evelyn Kowalewski / wife Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If any injury or once. 12/14/2006 | Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses pomeracu 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia Aspiration Physician disease or condition resulting in death) /Medical Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ettending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. this certificate has been signed by the rail director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 10 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1 No 1 Yes 2 1 No 1 Yes : After this certification of funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attenuing within 24 hours efter death.

To the Funaral Director: Aft 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Partifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064624 December 14,2006 12+1 who completed cause of death (Item 23a) (Type, Print) Dakwood Rd # 101 Glen Burnle, MD 21061 SANDEEP SHARMA 7845 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State DEC 2006 Registrar

State of Maryland / Department of Health and Mental Hygien

		1	1 - State Registrar			Ce	rtificat	e of L	Death			Reg. No		-, 00.
2	. ««		1. Decedent's Name (First, Middle, La	ist)							2. Date of De	eath		3. Time of Death
	Physici		JEANNE G	KROM	4E						Month	130a	ZOO 6	2:31A M
	/Medic		4a. Facility Name (If not institution, given				4b. City,	Town, or	Location of		vec_		. County of Dea	
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1,01	unaval				7. Age (In yrs. I	ast birthday)	If Under	r 1 Year	If Under		8. Date of Bi	rth		
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400	il ector		Usual Residence of Decedent								07/10/	1721	•	TID
land	A TI		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
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ath	23	Funeral	3119 BANCROFT RO		~				21215			1		USA
ab re	E E	nue	11. Marital Status	Armed Fo			Was Dece If Yes, spe	dent of H cify Cuba	ispanic Ori n, Mexican	gin? (Spe ı, Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	
a a de	P E	Y F	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	re e		1 🗆 Yes	2 X No	Specify:				Specify:	WHITE
275-0036 Thin 72 hours at	- 5	d by	3 X Widowed 4 □ Divorced	Year or Da	ates:								5,000,0	111212
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Maryland d 2 should be file	and a		19a. Informant's Name/Relationship	Туре, Print)		19b. Maili	ng Address	s (Street a	and Numbe	or Rura	l Route Numb	er, City	or Town, State, .	Zip Code)
end 2	C N. S.		DEBORAH KROME /	DAUGHTE	R	3119	BANC	CROF1	ROAL) #D	- BALT	IMOR	E, MD 2	1215
o	item 27		20a. Method of Disposition		20b. P	lace of Dispo	osition (Na	me of			ate		ocation - City or	
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	J = 0		1100001	- Chu		7							SVILLE,	MD 21208
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	*	ē	Sequentially list conditions, if any, leading to immediate		or as a consequ			/			· · ·			1000
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Sertific 5	attending ph for use as t	Me	IF FEMALE:											
ğ 4	tend or us		23b. Was decedent pregnant	23c. If yes, out 1☐Live b	come of pregna		⊒Ectopic p	regnancy					23d. Date of de	
Geat!	ed fo	2	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐ Pregn 9☐ Unkno	ant at time of de		Other (sp						Month	Day Year
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s the	pe de	by	Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	inderlying o	cause givi	en in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
i i	n sig		DIABETES	MELL	1705						10	Yes 2	□No 3□P	robably 4 Hinknown
0 8	shoi	Completed	OSTEOPO	ROSIS							24a. Wa:	5 20	24h Wore a	stooms findings available
<u>a</u>	hes Je 2	m	00.0010	1007							auto		prior to death?	utopsy findings available completion of cause of
	, pag										1 Yes	2 1	1 Yes	2 □ No
/It	this certificate hes al director, page 2	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)		
hysi	his c I dire	ို	1 ☐ Yes 2 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatie	nt 3 D0	OA Oth	er: 4 Nu	rsing Hor	me 5 Res	idence	6 □Other (Spe	icity)
DIVISION OF VITAL RECORDS, to Attending Physician: The law requires t	affer death. Director: Affer th in by the funeral		27. Manner of Death Natural 5 □ Pending	28a. Date	of Injury th, Day Year)	28b. Time o	of a	28c. Injun Wor	at	2	28d. Describe	how inju	ry occurred	
<u>o</u> i	in Af	atic	Natural 5 Pending 2 Accident investigation		,,	,,	М		Yes 2	No				
VIS	ecto ecto by th	If C	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determine	286. Place	of Injury - At ho	me, farm, st	reet, factor	y, office		- 2	28f. Location	(Street ar	nd Number or R	ural Route Number,
	d in	Certification:	4 Hollicide	buildi	ng, etc. (Specify	/)					City or To	own, State	9)	
spits	within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attent completely filled in by the funeral director, page 2 should be detached for us		29a. Certifying P	hysician: To the	best of my kno	wiedge, deat	th occurred	at the tin	ne, date an	d place. a	and due to the	cause/s) and manner a	s stated.
e Ho	Fu efely	Medical	(Check only 2 Medical Exa	miner: On the bi	asis of examinal ner stated.	tion and/or in	rvestigation	n, in my o	pinion, dea	th occurre	ed at the time	, date an	d place, and due	to the cause(s)
o the	o the	Me	29b. Signature and title of certifier				29	c. Licensi	e number			29d. Da	ite signed (Mont	h, Day, Year)
i i	3 ⊢ ŏ			MD						~				
•			2 July 20				L		1 21	,		DEC	- 13	, 2000
j			30. Name and address of person who Shawnmara	completed caus	e of death (Item	23a) (Type,	, Print)	-	20	511	アだっ	0	COLUM	BIA
			SHAWNMALA	COPT	A 4650	O SAY	VTIA	40	14)	-01	11611	0	MO	21047
1	Sta		31. Date filed (Month, Day, Year) DEC 1 5 2006	32. R	egistrar's Signa	ture	0							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Enrico Elio Laudi December 14, 2006 1:58 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Upper Chesapeake Medical Campus Harford Bel Air 5. Social Security Number if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1**∑** M 2□ F 17. Director 213-82-9451 1962 Maruland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 U.S.A. 1505 Huntfield Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: 3/17/96 015 8 altimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Depertment of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the once. Interpreter/Patient Coordinator Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laudi Vittorio Maria Pia Riccardi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1505 Huntfield Way, Jarrettsville, MD 21084 Giovanna M. Laudi (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 X Other (Specify) Entombrent Dulaney Valley Maus. 12/18/2006 | Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Ligensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lewony O soreumo /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury that initiated events resulting in death) Last Examiner ordier Due to (or as a consequence of): OUGH of Vital Records, 6.6. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Atter this certificate has been signed I funeral director, page 2 should be det Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2ER/Outpatient 3 DOA 1 ☐ Yes 25 🗘 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

8

State Registrar Steven Bentman MD

31. Date filed (Month Day, Year)

15 2006

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

520 Upper Chesapeake Dr., Bel Air, MD 21014

D0036487

06-09452 John Long Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Oecedent's Name (First, Middle, Last) Physician/ 2. Date of Death **Medical Examiner** JOHN EDWIN LONG 1525 hrs December 11, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Oeath 4c. County of Oeath Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DO/YYYY) 9. Birthplace (State or Director Months Days Hours Min 217-02-1277 1 X M 40 2 6~2~1966 Country) MD. Usual Residence of Deceden 10c. City. Town or Location 10d Inside City Limits s 23a or 28a-f show e notified at once, Marvland Baltimore Baltimore County Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 1 Yes 2 X No rector 10e Street and Number 10f. Zip Code 10g. Citizen of What Country ā 6 Joni Court 21234 USA 11. Marital Status 12. Was Oecedent Ever in U.S. 13. Was Oecedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? Never Married 2 X Married White, etc. <u>-</u> X Yes Yes, Give Year 1988-1992 Divorced 1 Yes 2 X No specify White 'natural' Specify ð 15 Oecedent's Education (Specify only highest grade completed) Oecedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sheriffs Dept. Baltimore, MD 21215-0036 the Medical other than 12 yrs. 2 yrs. Chief Deputy Ozark Co. Mo. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked Be John Lona Dorothy May Brantley 19a. Informant's Name/Relationship (Type, Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Kimberly L. Long (Wife) # 6 Joni Court Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State XX Burial 2 or other Cremation 3 Removal from State crematory or other place) Garrison Forest Cem. 12~15~06 Other Specify Baltimore, md. Donation 5 22. Name and Address of Facility E 7401 Belair Rd. Lassahn Funeral Home Baltimore Md or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and Hypertensive atherosclerotic cardiovascular disease Death Immediate Cause (Final disease ₹xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Oue to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED #23a,27,perME g863, 1/10/07 TI Box 68760. IF FEMALE phy the b 23c. If yes, outcome of pregnancy 23d. Oate of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Fetal death Oav Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown a Unknown Part II. Other significant conditions Ö contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, P. Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 ✓ Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other 4 Inpatient 2 **V** ER/Outpatient DOA 1 🗸 Yes Certification; To Nursing Home 5 2 Residence 6 Other 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical within 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. December 12, 2006 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

			1 - For State Registrar		Maryland			of Health and of Death		Reg. N	$Z \cup U$)6	40017
*	Physicia	an i	Decedent's Name (First, Middle, Las						2. Date of Month		ay	Year	3. Time of Death
	/Medic		Joseph	Е.		Le	ntz		Decen		11,	2006	11:00 P M
	Examin	er	4a. Facility Name (If not institution, give		•			m, or Location of Dea	ith	4		of Death	
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X	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
twarn	Marylar f ehow	ō	Maryland Baltimon	ro		Dund	alk						1 ☐ Yes 2X No
7	288	rect	10e. Street and Number			Dana	10f. Zip Cod	de		10g. (Citizen of	What Cou	ntry?
Ĭ.	3a or	Funeral Director	7607 Riddle Avenue	2			1	21224			USA		,
	ms 2	Jera	11. Marital Status	12. Was Deced		. 13.		of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or	No-			can Indian,
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3, 8	ral', c	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Date	es:		ILIYes 2XL	No Specify:			Specii	y: Whi	te
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Healin and Mental Hygiens. If Healin and Mental Hygiens, then 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual Oc	ccupation	orkina	16b.	Kind of B	lusiness/In	dustry
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qMe aryland	tal Hid oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	,	dle, Maid	en Sumai	ne)	
Z S	should and Men	To	Joseph Lentz					Anna					
Nayland Maryland	2 sh and r ls m		19a. Informant's Name/Relationship (7					reet and Number or F					
	fealth		Joseph Lentz Jr.	so	The state of the s			Court, R			•		
o <u>r</u>	ges 1 t of F If Ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from St	cen	netery, crei	sition (Name o natory or other	place) Dec	ember				own, State
틆	Pa tmen tant: jury		4 □ Donation 5 □ Other (Specify		Bayv		remator	- , 107	2006			ore,	MD.
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny Injury or ott		21 Signature of Funeral Service Licen	72n		2 7	Name and Aconnelly 110 Sol	y Funeral Llers Poin	Home Of t Road.	Dun	dalk, dlak	P.A.	21222
0	Physician /Medical		23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	used the death. ch line.	Do not ent	er the <i>m</i> ode of	dying, such as cardi	ac or respirato	y arrest,			Approximate Interval Between Onset and Death Years
760,	ite be iysicie ne bur	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Oro หนุ y r as a conseque r as a conseque		Arter	myopat, Ty Dist	ease				Years
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ords, F	w requires that been signed should be det	by	Part II. Other significant conditions of	ontributing to dea	th but not result	ing in the u	nderlying cause	e given in Part I.				tribute to t	he cause of death? pably 4 DUnknown
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Vit	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:	1.		1	26. Place of D	eath Check or	ly one)			
of	Phys this al dir	2	1 ☐ Yes 2 ☑ No	1 Jan 1		R/Outpatier			Home 5 F				fy)
E C	ding Ph h. After th funeral	on	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Day Year)	8b. Time o Injury		Injury at Work?	28d. Descr	be how in	jury occu	rred	
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Divi	tal or Al	Certification:	4 Homicide determined	28e. Place o	of Injury - At horn g, etc. <i>(Specify)</i>	ne, farm, str	eet, factory, off	fice	28f. Location City or	n (Street Town, Sta	and Numi ite)	ber or Rur	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the f	edical	29a. Certifier (Check only one)	ysician: To the b iner: On the bas and manne	is of examination	ledge, deat on and/or in	n occurred at the vestigation, in r	ne time, date and place my opinion, death oc	e, and due to curred at the til	the cause ne, date a	(s) and m nd place,	anner as s and due t	stated. o the cause(s)
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	15		30. Name and address of person who of	completed cause	of death (Item 2	23a) (Type,	Print)	Rd 611=	co d+	ر ، م		MA	13,20d
tops,	Sta	to	31. Date filed (Month, Day, Year)		gistrar's Signatu	re L	iyon 1	10 , 5111	411	C/7	4-1-1	VID	21042
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UUS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 10, 2 vol **Physician** Emil Languer, Jr. 12154 /Medical Town, or Location of Death Facility Name (If not institution, give street and number 4c. County of Death Examiner Rolamore Washington Michael en Gurnie 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Months Days Hours Min. 215 05 3284 92 Director May 23, 1914 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 K No Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 229 Doris Avenue 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 11 Marital Status 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman Shipping 8th Department of Health and Mental Hygis Important: If item 27 is marked other I any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Emil Languer, Sr. Marie Schmidt 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Languer / Daughter 229 Doris Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 12/13/2006 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lumomi **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions During for on each Examine tany, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury -1-∰Natural (Month, Day 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certif 29c. License number ပ္ 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VVF 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-09478 State of Maryland / Department of Health and Mental Hygiene Mary H. Murdock 1- For State Certificate of Death Registrar Time of Dea 2. Date of Death edent's Name (First, Middle,Last) Physician/ December 12, 2006 1311 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randallstown **Baltimore County** North West Hospital 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or If Under 1 Year If Under 24Hrs 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Foreign Hours Days Director Country) М 218-42 Usual Residence of Deceder 10d Inside City Limits 10c. City, Town or Location 10b. County iny 1 Yes 2 No 28a-f show ak hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or USA wood 10 14 Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Never Married 2 Married Yes , or Divorced If Yes, Give Year 1 Yes 2 No specify Black Widowed tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 1 ment of Health and Mental Hygiene ant: If item 27 is marked other than "r Baltimore, MD 21215-0036 sistan anage 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ENTU 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 wood DW 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Burial 2 Cremation 3 Department of Important: 1 12-20-06 WINGS Donation 5 Other Specify 21 Signature of Funeral Servi 22. Name and Address of Facility Chatman-Harris R 21215 B altimore 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each line /Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, of any, leading to immediate Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last pur Physician/Medical AMENDED UNPENDED physician the burial -Division of Vital Records, P.O. Box 68760, 23c. If ves, outcome of pregnancy 23d Date of delivery IF FEMALE 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 ✓ No 3 Probably 4 Unknown Hepatic Steatosis Completed 24h Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? this certificate has ✓ Yes page Yes 2 Nο 26. Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be examiner? Hospital 1 Inpatient 2 ✔ ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes No 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) After 28b Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) To the Funeral D determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie December 13, 2006 O.C.M.E.

OŘÍGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Susan Hogan MD. 31. Date filed (Month, Day, Year,

Assistant Medical Examiner

32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

OCME 2006

		1	For State Registrar	State of Marylar			of Health a of Death	nd Mer		ene 3. No. 2 (06	40020
			Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day	Year	3. Time of Death
	Physicia	_		Katty	Martine	z-Cru	Z	Т	Decembe			4:00 P M
>	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	own, or Location of				y of Death	
	Xuiiiiii	Ψ'	107 N. Highland A	venue			Baltimor	ce Cit	-y	N/		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Months		4 Hrs. a	Date of Birth (Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		219-69-9148	M 2 1 2 2	Yrs.				uly 9,		Mary	land
	2 ,	-	Usual Residence of Decedent 10a, State 10b, County	10c C	ity, Town or Lo	cation					10	Od, Inside City Limits
	aryla shov	2			.,,		Baltimor	e Cit	- 37			1√ Yes 2 No
	88-f	Director	Maryland N/A			10f. Zip C				g. Citizen of	What Coun	trv?
	with t		107 N. Highland	Assonise		101. Zip C						
	ilied within 72 hours after death with the Maryland Hygiene. Hygiene. The Hygiene then "natural", or items 23e or 28e-f show ent, the Medical Examiner must be notified at	Funeral		12. Was Decedent Ever in U	IS 13 V	Was Decede	21224 nt of Hispanic Orig		v Yes or No-		ed Sta	
	item item	5	11. Marital Status 1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ No		f Yes, specif	y Cuban, Mexican,	Puerto Ric	an, etc.)	Bla	ack, White,	etc.
36	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 X Yes 2	☐ No Specify:			Speci		panic
Š.	2 hou	bed	15. Decedent's Educ	cation	16a. Dece	dent's Usual	Occupation most	of working	1	6b. Kind of E		
212	7 uic a a	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	done during most retired)	or working				
2	d wit	Completed	N/A		De	ependa				N/A		
힏	oth vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother	r's Name (F	irst, Middle, M	laiden Suma	me)	
<u>a</u>	uld b Mentit	70	German Martinez					ngris				
Maryland 21215-0036	and lame		19a. Informant's Name/Relationship (Type				Street and Number					Code) 21224
Σ.	end alth		11192120	other)			Highland			imore		
ore	of Ho		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	temoval from State	Place of Dispo cemetery, crei	matory or oth	ner place)	Date		Oc. Location		
Ē	Pag ment ant: ury c	1	4 □Donation 5 □Other (Specify)	Ho			. Gdns.		/2006	Middle	e Rive	er, MD
Baltimore,	permit. Pages 1 and 2 should be ified within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If team 27 is marked other than "natural; or items 23e or 28e-f show eny injury or other traumatic event, the Medical Examinal must be notified at angle.		21. Sunature of Funeral Service License	" ('alo	1	Duda-R	Address of Facility uck Fune	ral H	ome of	Dunda	lk, Ir	nc. 222
			23a. Part1. Enter the disease, or compli	ications that caused the dea	ath. Do not ent	7922 W ter the mode	ise AVH.	cardiac or re	dalk Mespiratory arre	laryıaı st,	na Zi	Approximate
		J	shock er neart failure. List only or Immediate Cause (Final	ne cause on each line.	. 0	1.	in Ands	/	2:/110	0		Interval Between Onset and Death
<i>)</i>	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	eco pe	1/n/	01010	X	veun			
Н	Examiner			/ 3 (/	De ill	17 6	Chronti	c 1/	mein	doe	recot	7
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):						1	
	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c.								
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99	ng ph ng ph	Med	IF FEMALE:									
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П	e dea he at ed fo	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of 9 Unknown	death 5[Other (spe	cify)					,
P. 0.	at the	F.	9 Unknown	and have a death has not a	aculting in the .	andorhina on	use sweet in Part I		23e Did tob	accouse co	ntribute to t	ne cause of death?
ŝ	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:		Part II. Other significant conditions con	ninbuling to death but not re	asulting in the c	moenying ca	use giveri ili Faiti.		1 □ Ye	_/		ably 4 Unknown
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Division of Vital Records,	after Direction by	Certification:	4 Homicide determined	building, etc. (Spec		1001, 1401017,			City or Town	, State)		
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier Certifying Phy	vsician: To the best of my ki	nowledge, dea	th occurred a	at the time, date an	d place, and	d due to the ca	use(s) and r	manner as s	tated. o the cause(s)
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.			License number			9d. Date sign		
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7			rejulife) Mil	am (22a) (T	Seine)	1801 T	77 6		12	1,21	
)		30. Name and address of person who	peripieted cause of death (It	MA	VII			Eastern more, M		.a	224
	C+	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	nañere	asti)		oal UlI	wore, M	arārgi	<u>1</u> 4 2.1	2.2.4
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Villiam Michael McCoy	State of Maryland / Department of Health and Mental Hygiene	
1- For State	Certificate of Death	D 11

		1- For State Registrar	of Maryland / Departm Certific	cate of E	Death		Re	eg No.	006 4	002
Physicia al Exami		Decedent's Name (First, Middle,Last)					Date of Deat Month	Day Year	3. Time of I 1325 h	
ai Exaiiii	ner	William Michael 4a Facility Name (if not institution, give s			City, Town, or Lo	cation of Death	November	4, 2006 4c. County of		
		Potomac River near mile ma			Mulberry			Charles		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs, last bir		If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birt	th(MM/DD/YYYY)	Foreign	
Director			^M ² □F 53	Yrs.	Months Days	riodis Willi.	08/27/	1953	Country Virg	inia
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d		Prince		e City					1 Yes	
arylan 8a-f sl at onc	cto	VA William 10e. Street and Number	Date		Of. Zip Code		10	Og. Citizen of Wha	at Country?	
ise! I and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. The filem 21 is marked other than "natural", or items 23a or 28a-f show any ther traumatic event, the Medical Examiner must be notified at once.	Director	4111 Gardensen Driv	370		22193		,,	. C. V		
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ygien ygien other he Me	Complete	17. Father's Name (First, Middle, Last)					(First, Middle, N	faiden Surname)		-
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alth an	S	Judith G. McCoy -	Wife 4	111 Ga	rdensen on (Name of ceme	Drive,	Dale Ci	ty, VA 2	22193 City or Town, State	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year 12 12 2006 5:45p. McFadden Leroy 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore 6600 Spring Mill Circle Woodlawn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Months Hours 1**X**1X1 2□ F 66 Yrs. 247-62-4245 22 08 40 SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 ☐ No Woodlawn Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21207 6600 Spring Mill Circle 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scott Branch School Custodian 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Mae Fulwood Johnny McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6600 Spring Mill Circle, Woodlawn, Md 21207 Susie I. McFadden-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/18/06 Rosehill, NC Rosehill 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West 21215 300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes

Physician /Medical Examiner

physician

has

After

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

r 28a-f show notified at

items 23a or 3

9

natural"

and Mental Hygiene.

60

Department of Health ar Important: If Item 27 is any Injury or other trau

Director

Funeral

þ

Completed

Be 2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical þ Completed Be 은 s after deau... ral Director: Aftr within 24 hours aff

To the Funeral D

completely filled in

Certification; Medical

IF FEMALE: 23b. Was decedent pregnant 9 ☐ Unknown 25. Was case referred to medical examiner?

1 Yes

27. Manner of Deal

Natural Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

No No 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of injury - At home, farm, street, factory, office building, etc. (Specify)

26 Place of Death (Check only one) 3 DOA Other: 4 Nursing Home

Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Ste. 101 Balto. MD. 21244

and manner stated. 29b. Signature and title of certifier

Blvd.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 shast une 31. Date filed (Month, Day, Year) State

Registrar's Signature

7004

Security

Registrar

			State of Maryland / Dep	partment of Health and Itertificate of Death		-200	16 40023
-1	ų w		Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Beath	2. Date of Deat	eg. Noi— U L	3. Time of Death
	Physici		Armenella E.	Morris	12 Month	10 20	Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County o	
			4230 Flowerton Road	Baltimore		N	A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
he.	Director	5	216-14-3051 1 M 2LXF 87 Yrs.		08 22	19	VA
	land it		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Marylan -f show fied at	to	MD NA Baltimo	ore			1X Yes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of Wh	nat Country?
	th wit 23a o Ist be		4230 Flowerton Road	21229		U.	S.A.
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		- American Indian, White, etc.
2	or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No Specify:	, ,	Specify:	Black
2-0036	hours tural	d b		edent's Usual Occupation			
ņ	in 72 " na" r	olete	(Specify only highest grade completed) (Giv	re kind of work done during most of work DO NOT use retired)	king	l6b. Kind of Bus	iness/industry
7	with jiene. r thar	Completed	Elementary/Secondary (U-12) College (1-4or 5+)	Housewife		Hom	e
and		BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, M	faiden Surname)
<u>a</u>	ould be Mental larked c	TOE	Alfred Speaks	Mary K	ellam		
Mar	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Ru	ıral Route Number,	City or Town, S	tate, Zip Code)
	s 1 and of Health item 27 other tr			Forest Hill R			
Baltimore	Pages 1 nent of H int: If ite		Tabunal 2 Demation 3 Penioval noni State	position (Name of ematory or other place)			ity or Town, State
	tmen tant:				8/2006	Balti	more Co, Md
e D	permit. Pages Department of Important: If i any injury or once.		MANAIN I DAINI	22. Name and Address of Facility March F/H West			
-	4. E. J. A.		23a. Jart1. Enter the disease, or complications that caused the death. Do not e	4300 Wabash Ave			Md 21215 Approximate
		I	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	L so In	or respiratory arre	31,	Interval Between Onset and Death
	Physician /Medical	L	dease or condition esulting in death) Due to (or as a consent nce of):	ation			Imo
	Examiner		Due to (or as a conserve rice of).	40			2/10000
25		er	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying	119			syew is
	outed id ansit	Examine	that initiated events	chnoid hei	morrh	1003	2 3 Hens
Š.	be execui		resulting in death) Last Due to (or as a consequence of):			1	7
0/9 0/9	cate be executed bhysician and the burlal-transit	dical	d				
Ŏ	certificate Iding phys	Mec	IF FEMALE:			1	
X D	death o	Physician/Me	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date Mont	· ·
j.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)			,
r.	that ed b deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contrib	ute to the cause of death?
cords	requires een sign rould be	d b	Seizure disorder		1 ☐ Ye	s 21 <mark>⊠</mark> No 3	Probably 4 Unknown
ទូ	law req as beer 2 shou	lete	Diabeta mellitus II		24a. Was an	24h W	ere autopsy findings available
Ĺ	he la e has age 2	Completed by	Huno Longino		autopsy perform	/ pri led? de	or to completion of cause of ath?
V Ital	an;] tificat tor, p	Be C	25. Was case referred to medical	26. Place of Dea	th (Check only one	<i>D</i>	☐Yes 2☐No
>	ysici is cer direct	To B	exàmmer? 1	Othor	ome 5 Resider		(Specify)
0	ng Ph ter th neral		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) Injury		28d. Describe how		
VISION	endir sath. or: Al	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Ĕ	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,		or Rural Route Number,
_	urs al		20-0-17-				
	Hos 24 ho Fun stely i	Medical	29a. Certifier (Check only one) Check only one) Check only one) 1	nvestigation, in my opinion, death occu	, and due to the ca rred at the time, da	use(s) and mani ite and place, ar	ner as stated. Id due to the cause(s)
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Mec	29b. Signature and title of certifier	29c. License number	29	d. Date signed ((Month, Day, Year)
	F ≯ F Ó		Holy & Bolows MO	2005280	17 1	2/12.	12006
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	1/	2/2/	-000
	5		LesliesRobinson, MD. 29 SPac	coct Baltin	ore M	1 212	01
	Sta		04 D-1- (1 + 44 + 4 D - V - 1	audi)) -1	- 10	
	Registr	ar	DEC 1 5 2006	And the second			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year De 7:25 PM 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tospita 8. Date of Birth (Month, Day, Year) 12-20-75 Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 **X**F Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic and injury or othe 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Kes 2 No Completed by Funeral Director BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 21207 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ashie N A Be ဥ 9a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Bural Route Number State, Zip Code) 21207 othe issandra Mi Jone 20a. Method of Disposition 20b. Place of Disposition (Name of centerery crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such 🖈 cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hemorrhage Iday /Medical Due to (or as a consequence of): Examiner andida Endocarditis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Candida fungemia or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 🗌 No 3 Probably 4 dunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has t autopsy certificate 2LI No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 212 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 npatient within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Union Memorial Makeshware hospita haru MID 31. Date filed (Month, Day, Year) 32: Registrar's Signature State DEC

DHMH 17 Rev 1/2001

Registrar

5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month Year **Physician** 5: 15 AM 12 KATIE MADDOX /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AUGSBURG NURSING HOME LOCHERN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days 1 ☐ M 2 🗷 F Yrs. NC 217-20-7430 82 Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show rthan "natural", or Itams 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 KNo Director BAMMORE GWYNN OAK am 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 6811 CAMPFIELD 21207 ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 Specify: Completed by BLACK 3 Midowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked othar than Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER DOMESTIC 121H GRADE NA traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H f Itam 27 is marked oth FLOYD SATTERFIELD BERTHA SATTERFIELD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LANE, BALTO. MD 21216 KOK0 1000 YOES Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of HImportant: If Ital
any injury or oth 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 12.14.06 BAUTO. GREENMOUNT 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATC PLKE, BALTO. 1110 21229 21. Signature of Fureral Service Licensee aughn Approximate Interval Between Onset and Death 23a. Part 1. Ent (tb) disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HIZNEIMENS **Physician** 18avs /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duy to for se a consequence off Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a id be detached for o. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2)X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4- Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 737573 December 12, 2006 3 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MD 21136 Mais MA 25 57. 716 ell Ief

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 15

2006

32. Registrar's Signature

	1 - For State Registrar	•	Certificate of Death	Reg. I	0000 10000					
Physician	1. Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year					
/Medical	Ethel Jane Matara			December						
Examiner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death Towson	1	4c. County of Death Baltimore					
Funeral	5. Social Security Number 6. S	ex 7. Age (In yrs. last birth		8. Date of Birth	O Diethylass (Otata av Favrins					
Director	088-01-2345		rs. Months Days Hours Min.	(Month, Day, Yea	ar) Country)					
pur N	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits					
laryla show					1 □Yes 2 □ No					
the N 28a-1 notifi	Md. Harfo	ord	Monkton 10f. Zip Code	100	Citizen of What Country?					
ifter death with the Mai r Items 23a or 28a-f si liner must be notified Funeral Director	3604 Myladys View	v Court	21111	log.	U.S.A.					
ms 2 r mus	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,					
urs after st., or ite xamines	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	if Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Hican, etc.)	Black, White, etc. Specify: white					
2 hou natura ical E	15. Decedent's Ed	ucation 16a. [Decedent's Usual Occupation	16b	. Kind of Business/Industry					
ed within 72 horygiene. Ter than "natur: t, the Medical E Completed	(Specify only highest gra	College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	King						
led will ygien the the the tr., the Con	12 years		memaker		own home					
be fill He ad out even	17. Father's Name (First, Middle, Last) Richard Nicholls			ne (First, Middle, Maid	den Surname)					
d Men marke matic To	19a. Informant's Name/Relationship	Time Print) 19h	Ethe 1 Mailing Address (Street and Number or Ru		the or Town State 7's Code					
and 2 s	Maud E. Ziegler/		004 Myladys View Cou							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the context o	Removal from State cemetery	Disposition (Name of commatory or other place) Valley Mem. Gdns.		Location - City or Town, State					
permit. F Departm Importar any Injur once.	21. Signature of Funeral Service Licer		22. Name and Address of Facility Schimunek Funeral							
00560	222 Part 1 Enter the disease or com	clientions that sourced the death. Do no	610 W. MacPhail Ro	ad, Bel Ai	Cr, Md. 21014 Approximate					
	shock, or heart failure. List only		ot enter the mode of dying, such as cardiac		Interval Between					
Physician /Medical	disease or condition resulting in death)	a. Conville 17 mg	of Amystrophiz (ateral sul	rosis months					
Examiner		240 10 (0. 40 4 00.000420.000 0.	جر <u>ر</u>							
it d	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
rificate be executed by physician and as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	C	Α.							
be ex ician burial		Due to (or as a consequence of	1).							
ifficate be ig physicia as the bu		d								
nding use a	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy			23d. Date of delivery					
The law requires that the death cert ate has been signed by the attending page 2 should be detached for use completed by Physician/M.	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year					
by the tache	9 □ Unknown	9□ Unknown								
w requires that the debe been signed by the should be detached letteched by Physic	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the cause of death?					
sen si rould				1 🗆 Yes	2 No 3 Probably 4 Unknown					
: The law requi				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
				performled 1□ Yes 2 X	2 death? No 1 □ Yes 2 □ No					
certifi ector	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	4 / /					
Physical direction of the control of	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Ti	patient 3 DOA 4 Nursing H	ome 5 Residence	/					
h. After fune tion	1X Natural 5 ☐ Pending investigation	(Month, Day Year) In	jury Work? M 1 Yes 2 No	Zou. Describe flow if	njury occurred					
Atten deat sector: by the	3 Suicide 6 Could not be	28e. Place of injury - At home, farr		28f. Location (Street	t and Number or Rural Route Number,					
Ital or Attending R rs after death. ral Director: After led in by the funer. Certification:	4 Homicide determined	building, etc. (Specify)		City or Town, St	tate)					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and place l/or investigation, in my opinion, death occu	e, and due to the cause arred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
To th To th comp	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)					
. 2) Wa	~~~~)	058303	De	ecember // 2006					
\0	DANN S. CHAM	completed cause of death (Item 23a) (T WK MJ 6765 N	Type, Print) Cherk, St BRD	nne m	21204					
State	31 Date filed (Mostly Day, Year) 2	32 Registrar's Signature	anastis!							

06-09430

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Annee	Mitchell		State of Maryland / L I-For State Registrar		ent of Health an ate of Death	d Mental H	ygiene Reg.	No. 2000	1,0027
	Physicia	ın/	Decedent's Name (First, Middle,Last)				2. Date of Death	2000	3. Time of Death
Medic	al Exami		Ahnee Ayanna Mitchell 4a. Facility Name (if not institution, give street and number)		dh City Town or	Location of Death	Month December 1	10, 2006 4c. County of Death	2218 hrs
			Johns Hopkins Hospital		Baltimore	Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (I	n yrs. last birt	thday) If Under 1 Year Months Day			(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
	Director		597-46-4387 1 M 2 XF	11	Yrs.	710010	Feb. 2	7, 1995 ^{Co}	nPuerto ^{unity)} Rico
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town	or Location				10d. Inside City Limits
	* .	5	Maryland Anne Arundel		Jessup				1 Yes 2 X No
	Maryll r 28a-f ed at o	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	
	ath with the Maryland items 23a or 28a-f show ust be notified at once.	a D	7381 Cedar Avenue 11. Marital Status 12. Was Decedent Ev	er in IIS	13. Was Decedent of Hi	0794	pecify Ves or No-	United S	tates can Indian, Black,
	r death w or items must be	uneral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X		If Yes, specify Cubai			White, etc.	out in and it is a second
	after oral", or	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 Yes 2 X No	All and the second state of		Specify: Bla	
	72 hours after death with the Maryland n"natural", or items 23a or 28a-f she al Examiner must be notified at once	ted	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)		Decedent's Usual Occupa during most of working life			6b. Kind of Business/	none
036	ithin 72 ne r than ledical	Completed	6		studen	t			
0-5	Hygie d other		17. Father's Name (First, Middle, Last)	•		18.Mother's Name	, ,	,	
727	lld be f Mental narke event	e Be	Harold J. Hildreth 19a. Informant's Name/Relationship (Type, Print)	191	b. Mailing Address (Stre		ne Mitch		. Zip Code)
2	2 shouth and 27 is unnation		Angeline Mitchell/ mother	73	381 Cedar Av	enue, Je	ssup, MD	20794	
ā	s I and of Heal If item	ſ	20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State		of Disposition (Name of ce tory or other place)	metery,	Date	20c. Location - City or	Town, State
Baltimore MD 21215-0036	permit Pages I and 2 should be filed within 72 hours after de permit Pages I and 2 should be filed within 72 hours after de Important: If item 27 is marked other than "natural", or injury or other tranmatic event, the Medical Examiner mu		4 Donation 5 Other Specify:		gton Nat'1 C	em. 1/	2/07	Arlingto	n, VA
<u>e</u>	permit Depar Impo		21. Signature of Funeral Service Licensee Denical Service Democle D		22. Name and Addres Crematory,	P.A. 141	aldson F	uneral Hom lis Rd. Od	entoni1MD
	hysician /Medical		23a Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.		ot enter the mode of dying	, such as cardiac c	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Complication Due to (or as a consequence)		erebral pelsy				Death
	ĵ		Sequentially list conditions, b						
		iner	if any, leading to immediate Due to (or as a consequence. Enter Underlying Cause C.	ience of):					
7	od Esit	xan	events resulting in death) Last Due to (or as a consequence of the co	ience of):					
m	arth certificate be executed attending physician and or use as the bunial - transit	Medical Examiner	XUNPENDED AMENDED #00						
9	certificate be e	Med	IF FEMALE: #Z3a. If yes, outcome	.27.perly of pregnancy	Æ, g863 1/22/0	<u>7 TT</u>		23d. Date of deliver	/
Roy 687	certific nding p	Physician/	23b. Was decedent pregnant in the past 12 months?	ne of death	Fetal death 3 Other (Specify)	Ectopic pregna	ancy	Month I	Day Year
Š	the atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown		other (Specify)				
	ires that the d signed by the	by PI	Part II. Other significant conditions contributing to death b	ut not resultin	ng in the underlying cause	given in Part I.	Consessaria .	acco use contribute to	
<u> </u>	quires en sign						24a. Was ar		itopsy findings available
2	thas been e 2 should	Completed					autopsy	ed? death?	completion of cause of
9	ysician: The l ysician: The l his certificate l director, page		25 Was case referred to medical		26 Plac	e of Death (Check	1 Yes 2	No 1 Y	es 2 No
Z E	VICA hysicia this cer I direct	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient	2 ER/0	Outpatient 3 DOA	Other Nursin	ng Home 5 R	esidence 6 Othe	r:
Oivision of Vital Becords D	ding Physical After this funeral dir	Di: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year	28b.		ury at Work? Yes 2 No	28d. Describe ho	w injury occurred	
	Attend r death ector: by the	icati	2 Accident Investigation 28e Place of Injur	v - At home, fo	farm, street, factory, office		28f. Location (St	reet and Number or Ru	ıral Route Number, City
2	Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	,	,,,		or Town, Sta		
			29a Certifier 1 Certifying Physician: To the best of my k						
	To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated 29b. Signature and title of certifier	nation and/or		se number		29d Date signed (Mo	
<i>y</i>		2	Question and the or certifier			.M.E.		December 11, 2	
	Φ.	W	30. Name and address of person who completed cause of dea	ith (Item 23a)					
	4	1	Ana Rubio MD. Assistant Medical Examin	ner 111	Penn Street, Baltim	ore, MD 2120	1		
	S Regis	tate trar	31. Date filed (Mon DEaCY ar) 5 2006 32. Refistrar's	Signature	Asses				
	~ ``								

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Ovid McKoy									

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State of Maryland / Department of Health and Mental Hygiene

via ivickoy		I- For State	paryiand / Departi Certifi	ment of i		u Meni		Reg No 200	6 40028			
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last)					2. Date of Dea	- 3	3. Time of Death 1012 hrs			
ledicai Exami	ner	OVID MCKOY 4a. Facility Name (if not institution, give stree	at and number)	46	o. City, Town, or	Location o		er 6, 2006 4c. County of De				
,		7014 Park Heights Avenue			Baltimore				[A			
Funeral Director		5. Social Security Number 6. Sex 18.62.9937 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last I	birthday) Yrs	If Under 1 Year Months Day		Min.	rth(MM/DD/YYYY) 9. For	Birthplace (State or eign Country) MD			
any	}	Usual Residence of Decedent 10a State 10b. County	10c. City, To	wn or Location	n				10d Inside City Limits			
<u> </u>	ō	MO NA	BALTIN						1 Yes 2 No			
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Director	1012 PARK HEIGHTS	AVE.		10f. Zip Code 2121	5		10g Citizen of What Co	-			
ath with tems 23.	neral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?		Decedent of Hi	spanic Orig	in? (Specify Yes or N Puerto Rican, etc.)	0- 14. Race - Am White, etc.	erican Indian, Black,			
after de al', or i	by Fune	3 Widowed 4 ♥ Divorced If Yes or Da	tes:		res 2 🕱 No			Specify BI	ACK			
2 hours "natur		15. Decedent's Education (Specify only hig Elementary/Secondary (0-12)	hest grade completed) 16 follege (1-4 or 5+)		s Usual Occupa st of working life		ind of work done use retired)	16b. Kind of Busines	s/Industry			
1036 vithin 7. ene er than	ompleted	12 TH GRADE	NA	LAB	ORER			CONSTRL	ICTION			
ore, MD 21215-0036 set and 2 should be filed within 72 of Health and Mental Hygiene. If item 27 is marked other than 'her traumatic event, the Medical	Be Co	17. Father's Name (First, Middle, Last) OVID L. MCKOY					S Name (First, Middle,	,				
D 2121 should be fil and Mental b is marked atic event, p	10	19a. Informant's Name/Relationship (Type, F			Address (Stre	et and Numi	ber or Rural Route Nu	mber, City or Town, Sta	ate, Zip Code)			
e, MD 2 I and 2 shou Health and I item 27 is r		20a. Method of Disposition	20b. Plac		on (Name of ce		Date	700 2120 20c. Location - City	or Town, State			
Baltimore, permit Pages I an Department of He. Important: If ite		1 Results 2 Cremation 3 Results 2 Donation 5 Other Specify:	anoval nom state	PARK			12.12.06	RANDAUS	TOWN, MD			
Baltimo permit Page Department Important: injury or ott		2 Signature of Funeral Service Licensee		22. Na VAU	me and Addres	s of Facility	SE FUNERA	L SERVICE D. MD 2121	20			
Physician		23a. Part I (Enter the disease, or complication failure. List only one cause on each line	ns that caused the death. Do	not enter the	mode of dying	, such as ca	rdiac or respiratory ar	rest. shock, or heart	Approximate Interval Between Onset and			
/Medical Examiner			herosclerotic car	rdiovasc	ular dis	ease			Death			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to	o (or as a consequence of):									
	Examiner	Course Enter Underlying Course (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of).										
executed an and al - transit		events resulting in death) Last Due to	(or as a consequence or).									
60, are be execut hysician and le burial - tra	Medical		#23a,PII,2		g862, 1	2/18/06	TT	Locus				
6876 ertificat ding phr	sician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year										
Box 687 ne death certific the attending p	Physic	1 Yes 2 No 9 Unknown 9	Pregnant at time of death Unknown	5 Othe	er (Specify)							
, P.O. B ires that the disigned by the be detached:	by PI	Part II. Other significant conditions control Human immunodeficienc	-			-		obacco use contribute	to the cause of death?			
ords, v requires s been sig	Completed	Hairi minasotericies	, , , , , , , , , , , , , , , , , , , ,	(02212		01)	24a Was		autopsy findings available o completion of cause of			
Reco The law cate has	omo							ormed? death	?			
Vital Rec ysician: The his certificate I	Be	25. Was case referred to medical examiner?		3/0-41		e of Death (Check only one)	Builden of Con				
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been sided in by the funeral director, page 2 should be	n: To	1 Yes 2 No 27. Manner of Death	i inpatient 2 En	R/Outpatient 3b. Time of Inj		ry at Work	Nursing Home 5 28d. Describe	Residence 6 Oth	ner: Scene			
ivision or Attendia after death Director:	catio	2 Accident Pending				Yes 2						
Divis pital or At ours after d ceral Direct filled in by	Certification:	Suicide 6 Could not be	28e. Place of Injury - At home (Specify)	e, rarm, street,	, ractory, office	bullaing, etc	or Town,		Rural Route Number, City			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C	one) 2 Medical Examiner: On the	o the best of my knowledge, ne basis of examination and/o									
E 3 E 8	Me	29b. Signature and title of certifier	16 114		29c Licen:			29d. Date signed (A				
		Missa, Massel 30. Name and address of person who compl	eted cause of death (Item 23	Ba)	0.0.	IVI. L.		December 7, 2				
		Melissa Brassell, MD Assist	ant Medical Examiner		enn Street, I	Baltimore	, MD 21201					
St	tate	31. Date filed (Month, Day, Year) 2006	32 Registrar's Signature	2004								

			For State Registrer	State of Marylan		artment of F		Mental Hy	rgiene Reg. No.2 0 0 6	40029			
	Physicia /Medic		Decedent's Name (First, Middle, Last)	Marax	ichu	cK		2. Date of De Month	Day Year	3. Time of Death			
	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	4	4b. City, Town, o	Location of Dea	·	4c. County of Death	is			
	uneral Director		5. Social Security Number 6. Sex O90-28-0267 Usual Residence of Decedent	7. Age (In yrs.	Yrs.	Months Days	Hours Min		ay, Year) Col	pplace (State or Foreign Intry)			
death with the Maryland	or 28a-f ehow se notified at	Director	10a. State 10b. County 10b. County 10b. Street and Number	4. 10c. Cit	y, Town or Lo	Chin	cote	gu-e	10g. Citizen of What Cor	10d. Inside City Limits 1 2 No untry?			
5-0036 72 hours after death with	238	by Funeral	5003 4th A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 Hyes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ Ho	_						
Maryland 21215-0036	Department or nestin and woman Hygiene. Important: if item 2' is marked other than "natural; or itemes eny injury or other traumatic event, the Madical Examination once.	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		(Give	dent's Usual Occup kind of work done DD NOT use retired	during most of wo		16b. Kind of Business/I				
ryland	marked o	To Be		avanchick		ng Address (Street	Anna	stasi	1	in Code)			
Baltimore, Ma	ent of Realth ar nt: if item 27 ts ry or other trau		20a. Method of Disposition 1 Burial 2 Gerenation 3 Re 4 Donation 5 Other (Specify)	20c. Location - City or Town, State									
Balti Permit.	importa eny inju		21. Signature of meral Prvice License	The	1 2		of Facility	ralley D	r. Jessup, F	A 18434			
/IV	ysician Medical aminer		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): ADRTIC VALUE STENDS 15										
- 18-0267 8760, Co	attending physicien and for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	00375									
COYO O. Box 6	by the attending packed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3[□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of deli- Month	very Day Year			
ecords, P.	engi pe eq	Š	Part II. Other significant conditions conf	tributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		tobacco use contribute to Yes 2 □ No 3 □ Pro				
Maran C Vital Record sician: The law requir	certificete has been si rector, page 2 should I	Completed	25. Was case referred to medical		-			1 Yes	psy prior to codeath? 2 No 1 Yes	opsy findings available ompletion of cause of 2□ No			
of Vita	r this cert	To Be	examiner?		ER/Outpatier		er: 4 ☐ Nursing I		idence 6 Other (Spec	rfy)			
Division of	within 24 mous after the within certificate ha completely filled in by the funeral director, page completely filled in by the funeral director, page	Certification	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifi	k? Yes 2 □ No	28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Hospital	Funerai D	Medicai Ce	29a. Certifier (Check outy one) Certifying Physical Certifying Physical Examination	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)			
Toth	To the	Med	29b. Signature and Aftle of certifier	New M		29c. Licens			29d. Date signed (Month	1			
	3		30. Name and address of person who cor	1 63 17 1	23a) (Type,	Print) Salisbu	ry M's	, 2180	12/08 Kurtwe	hbergim. D			
	Star Registra		31. Date filed (Month, Day, Year) DFC, 1, 5, 200	32 Registrar's Signa	ture do	uli	-1			7			

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se Type or Print in Black Ir State of Maryland / Dep				400	3 (
Ce	ertificate of Death	Reg. N	lo.		
e, Last)		2. Date of Death Month December	ay Year	3. Time of De	
gan	1 0 2 T		9, 2006	8:00	A

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physiclan/Medical Examine

	1 - For State Registrar			Ce	rtificat	e of L	Death			Reg. No).		Engl &	
an	Decedent's Name (First, Middle, Last	st)							Month Day Year				3. Tin	ne of Death
al	Mary Helen Morgan	1							Decemb	er 9	, 20	006	8:	00 A ^M
er	4a. Facility Name (If not institution, give	e street and numb	er)		4b. City,	Town, or	Location	of Death		40	. County	of Death		
	4804 Morgan Drive	3			Che	vy C	hase			M	ont	omer	У	
	5. Social Security Number 6. S		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D	irth Day Year)	9. Birthp Coun	lace (St	ate or Foreigi
	210-09-3411	□M 2MF	88	Yrs.	Nontri	Days	Hours		March	5, 1	918	Penns	sÿ1v	ania
	Usual Residence of Decedent		1 4											
	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1		le City Limits
cto	Maryland Montgom	ery	Che	vy Cha	se								1 🔲	Yes 2 X No
İre	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of \	What Coun	itry?	
al D	4804 Morgan Drive				20	815				U.S	S.A.			
Be Completed by Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	.S. 13.	Was Dece	dent of Hi	spanic Or	igin? (Spe	cify Yes or N Rican, etc.)	10-		e - Americ		n,
Ξ	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2							Rican, etc.)		Bla	ck, White,	etc.	
by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes	2X No	Specify:				Specif	Whi	te	
ed	15. Decedent's Ed	ducation		16a. Dece	dent's Usu	al Occupa	ation			16b. k	(ind of B	usiness/Ind		
plet	(Specify only highest gra			(Give	kind of wo DO NOT u	rk doné d se retired	turing mos ')	t of workir	ng	Ī			,	
ma	Elementary/Secondary (0-12)	College (1-4 2	or 5+)	Hor	nemak	er				0	wn H	ome		
Ö	17. Father's Name (First, Middle, Last)			1101			18. Moth	ar's Name	(First, Middl					
Be	77								,	-,		,		
2	Harry Darr	Time Orient		105 14-10		(C)		ie No			_	O		
	19a. Informant's Name/Relationship (**			-				Route Num	•			Code)	
	Nancy Connors	(POA)	001 5		_				Chase,	-				
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Total cemetery, crematory or other place)										wn, Stat	9		
		'4 Demaion 5 Other (Specify) Bement Cemetery 12/15/06 Bement, IL												
	21. Signature of Funeral Service Licer	1596	····	,27	2. Name ar organ	nd Addres	s of Facili	ty						
	2 punes (F)	Marine		M	organ	Mem	oria.	L Hom	e West S	,		(10)	7 /	
Ť	23a. Part1. Enter the disease, or com	plications that cau	sed the deat	h. Do not ent	er the mod	te of dying	g, such as	cardiac o	respiratory	arrest,		918	Approx	mate
	shock, or heart failure. List only Immediate Cause (Final						-							Between and Death
	disease or condition resulting in death)	a Cardiopulmonary Arrest												
			as a conseq											
L	Sequentially list conditions. Alzheimer's Disease													
Ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o) of euc	as a conseq	uence of):										
am	that initiated events	c												
ŭ	resulting in death) Last	Due to (or	as a conseq	uence of):										
cal		d												
led														
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			Je					- 3	23d. Da	te of delive	ry	
Cla	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 Pregnan	n 2∏Feta It at time of d		Ectopic p						Mo	onth	Day	Year
nys	9 Unknown	9□ Unknow	'n											
γP	Part II. Other significant conditions of	ontributing to deal	th but not res	ulting in the u	nderlying o	ause give	en in Part I		23e. Did	tobacco	use cont	ribute to th	e cause	of death?
q p									1 [Yes 2	X No	3 ☐ Prob	abiv 4	Unknown
ete									-		-,			
ldu									24a. Wa aut	opsy	24b.	Were autor prior to con	osy findi npletion	ngs available of cause of
Con										fórmed? 2 ☑ No	, !	death? 1 🗌 Yes	2 🗆 No	
a	25. Was case referred to medical						26. Place	of Death	(Check only	one)				
To B	examiner? 1 □ Yes 2 🌠 No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatier	nt 3 🗆 D0	Othe	9f: 4 □ Ni	rsing Hon	ne 5 🗓 Res	sidence	6 □Oth	er (Specify	1)	
L:U	27. Manner of Death	28a. Date of (Month,		28b. Time o		28c. Injury Work			8d. Describe					
tio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		⊔ay rear)	Injury	м		<br Yes 2. □	No						
fica	3 Suicide 6 Could not b		Injury - At h	ome, farm, sti	eet, factor	y, office		2	8f. Location	(Street ar	nd Numb	er or Rura	Route	Vumber.
erti	4 Homicide determined	building	, etc. (Specif	y)		,				own, State				
Medical Certification:	29a. Certifier X Certifying Ph	veicion: To the h	not of my kn	wlodge do-t	h one	at the #	o deta -	d plans =	nd due to th	2 001:2-1	1007-			
lica	(Check offy 2 Medical Exam	ysician: To the beniner: On the base	is of examina	wieuge, deat ition and/or in	vestigation	at the time, in my op	ie, date ar pinion, dea	iu piace, a ith occurre	nd due to the d at the time	, date an) and ma d place,	anner as stand due to	ated. the cau	se(s)
Jec	29b. Signature and title of certifier	and marine	r stated.)		20	c. License	numbar			204 0	to sien-	d (Month, l	Day V:	

State

31. Date filed (Month, Day, Year)
DEC 1 5 2006 Registrar

ne and address of person who completed cause of death (Item 23a) (Type, Print)

D0064615

December 12, 2006

Rockville, MD 20850

			1 - For State Registrar	State of I	Marylar		artment <i>rtificate</i>			nd Me		giene2 Reg. No.	006	40031
ı	Physici		1. Decedent's Name (First, Middle, La William Art		an					2	Date of Dea Month	Day	O Year	3. Time of Death
)	/Medic Examir		4a. Fecility Name (If not institution, giv	e street and number	er)		4b. City, T	own, or Lo	cation of 0	Death			ounty of Death	
	_ Admin		146 S. Ellw	ood Ave	nue		Bal	timo:	re			n	/a	
	Funeral		5. Social Security Number 6. S	Sex 7.		last birthday)		Year If Days H		Hrs. 8	Date of Birth (Month, Day	h (Year)	9. Birthp	place (State or Foreign
	Director		219-32-7695	M 2□F	69	Yrs.	WORTH	Days	liours	William.	6-8-1	937		imore, M
Т	P .		Usual Residence of Decedent 10a, State 10b, County		10. 0									ad Instancia Circulturia
	aryla show	_	MD 10b. County n/a			ty.Town or Lo							1	0d. Inside City Limits 1 1 1 1 1 1 No
	8 a-f	Director												
	ath with the Marylan 23e or 28e-f show		10e. Street and Number	7 7			10f. Zip (1224				10g. Citizer US	n of What Cour ∆	ntry?
	death with the Maryland me 23a or 28a-f show rmust be notified at	Funeral	146 S. Ellw			15 112				-2/C	Yes as No		Race - Americ	an Indian
		Ë	t 1. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 Tes 21	s?		If Yes, specif	fy Cuban, N	Mexican, F	Puerto Ri	fy Yes or No- can, etc.)	14.	Black, White,	
გ გ	hours after ural, or Ita	by F	3 Widowed 4 Divorced	If Yes, Give	_		1 ☐ Yes 2	⊠ No S	Specify:			Sp	ecify: Whi	.te
15-003b		Ped	15. Decedent's E	ducation		16a. Dece	dent's Usual	Occupation	on			16b. Kind	of Business/In	dustry
2	within 72 ene. than "na	pie	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-40	or 5.4)	(Give	kind of work DO NDT use	done durii retired)	ing most o	of working			_	
7	d with	Completed	11th	College (1 4		Bake	er					A&P (Grocer	У
B	al Hy loth	Be	17. Father's Name (First, Middle, Last					18			First, Middle.			1
/lan	Ment Ment Prked	L P	Charles Wm.						Le	eono	ra I.	Von	Norde	CK
a	2 sho and is m		19a. Informant's Name/Relationship (Type, Print) Wi	fe								own, State, Zip	
≥ .	and eaith T 27 Tar tr		Vera L. Moran			146	S. E	llwo	od P	Ave.	, Bal	timo	re, MD	21224
o Te	of H		20a. Method of Disposition 1 28 urial 2 Cremation 3	Removal from Sta		Place of Dispo cemetery, crea	osition (Name matory or oth	e of ner place)						
	men men tent: jury		4 Donation 5 Other (Special		H	olly 1							imore,	
Saltimor	Permit Depar Tipor Iny in		21 Signature of Funeral Service Lice	1000	0									Jr. FH
_	40204		Joseph R	Venu		,							ore, N	Approximate
			23a. Part . Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.	tri. Do not en					1		1 '	Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a. CA	MA	5	VE	Van	<i>icu</i>	LAL	ANC	ay y	hmy	murke
	Examiner			Due to (or	as a consec	quence of):	Ca	WI	DN	md	Pas	ull		10 V/600
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	uence of):		1		11				is yes
d	uted ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cor	ررم	me	AFT	den	۱/	21	SEASE	-/		10 Years
<u>ה</u>	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consec	quence of)		/				7		1==-
0/8 0/8	ate be hysicia the but	dlcai	(d		/		/						
٥	death certificate e attending phys id for use as the	Med	IF FEMALE:			-								
X Q Q	eath certific attending p	an/	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			⊒Ectopic pre	gnancy				230	I. Date of delive	
	he at	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnan 9☐Unknow			Other (spe						Month	Day Year
Z.	requires that the de een signed by the a hould be detached t		Part II. Other significant conditions	contributing to don't	hut not en	tulting in the u	andosh in a ea		in Bort I		23a Did to	pacco use	contribute to th	ne cause of death?
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D C C C	red Peer Doc	etec	12017	7/10 3										acty Common
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ř =	: The cate he	ខ្ល									perfor 1 ☐ Yes	22 No	death? 1 ☐ Yes	2 No
VII	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other			Check only or			
0	di S	7	1 Yes No	1 🗆 Inp		ER/Outpatier 28b. Time o							Other (Specifi	γ)
	D 9 6	E E	1 Sending 5 Pending	28a. Date of I (Month,	Day Year)	Injury	M 20	ic. Injury at Work?	s 2∐No		d. Describe h	low injury o	ccurred	
DIVISION	Attending r death.	Ica	3 Suicide 6 Could not b	9 200 Blood of	Iniury - At h	ome farm st					f. Location (S	Street and N	iumber or Rura	I Route Number.
⋛	7 5 7 5	Certification:	4 ☐ Homicide determined	building	etc. (Speci	fy)	, , , , , , , , , , , , , , , , , , , ,	OHIOO			City or Tow			. , , , , , , , , , , , , , , , , , , ,
	political de la contra del la contra del la contr		29a. Certifier 12 Certifying Pl	nysician: To the be	st of my kn	owledge, deat	h occurred a	t the time,	date and p	place, an	d due to the d	ause(s) an	d manner as si	ated.
	To the Horwithin 24 h To the Fur	edical	(Check only 2 Medical Example)	miner: On the basi and manner	of examina	ation and/or in	vestigation, i	in my opinio	ion, death	occurred	at the time, o	date and pla	ace, and due to	the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	2-0				License nu		~			igned (Month,	
•			aut of	Det-	~ ~	7	9	D 3	577	00	5	12.	13.0	06
	10		30. Name and address of person who		of death (Ite	m 23a) (Typo-	Print)	C, N	201	۷ ،	m	-	13.0	z eL
			3243 ELL 31. Date filed (Month, Day, Year)	1014 32 Abo	strar's Sign	ature /	>AU	4/11	we	- 1	1	-	- 1 - 2	- T
	Sta	ιte	NFC 15	2008	and order	AS A	COALL!							

06-09432 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jack McClung State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical Examiner Jackie Eugene McClung 2340 hrs December 10, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1502 Frederick Road Catonsville Baltimore County 9 Birthplace (State or Foreign West Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY **Funeral** Months Davs Hours 291 28 3617 XM Director 71 04/03/1935 2 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d Inside City Limits N/A Maryland Baltimore s 23a or 28a-f show e notified at once. or 28a-f show 1 X Yes 2 No nours after death with the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3022 Lorena Avenue 21230 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Black or items 2 must be r Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 1 X Yes Specify: White 3 Widowed 4 Divorced If Yes, Give Year 1952 1 Yes 2 X No specify narked other than "natural", event, the Medical Examiner þ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene Baltimore, MD 21215-0036 12th Salesman Truck Equipment 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) marked (Thelma Moneypenny Cecil McClung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m r traumatic e Mary McClung / wife 3022 Lorena Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State Department of He Important: If it in injury or other t 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Bayview Crematory Baltimore, Maryland 12/12/2006 4 Donation 5 Other Specify 22 Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature or Funeral Service Licer death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Enter the disease, or complications that caused the Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Complications of hip fracture Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death and Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED #23a,PII,27,28a-f, perME g863, 1/10/07 TT #1. Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Chronic obstructive pulmonary disease 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a Was an 24b. Were autopsy findings available Atherosclerotic cardiovascular disease autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medica 26 Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Yes 2 No 2 X Accident 11/5/2006 unknown subject fell 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be

within 24 hours after deaus

To the Funeral Director: A

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3022 Lorena Avenue Baltimore, MD (Specify) residence Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certific 30 Name an laddress of person who completed cause of death (Item 23a) 29c License number 29d Date signed (Month, Day, Year)

December 11, 2006

O.C.M.E

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

Tasha Greenberg MD.

Medical

32. Registrar's Signature

Assistant Medical Examiner

and manner stated.

602 5 ATWOOD 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Moore-McCormack Lines Inc. 20c. Location - City or Town, State 12/15/06 Baltimore MD Approximate Interval Between Onset and Death 3 months 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? res 2 🔼 No 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 12-12-2006 MD 21014 BELATE

0124а м

Birthplace (State or Foreign Country)

Maryland

10d. Inside City Limits

1 ☐ Yes 2X No

Registrar DHMH 17 Rev 1/2001

1)

State

(Check only one)

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

5. SIVA SALLAM

29c. License number

ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 05:45 AM 2006 Dale W. Overholt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Agnes Hospital Baltimore Months Days Hours Min. R. Date of Birth (Month, Day, Feb 19, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 63 Yrs. 214-52-9101 1943 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be motified at 1 ☐ Yes 2 💆 No Baltimore Catonsville Directo Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 1502 Frederick Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk Federal Government 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event SING. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William F. Overholt Doris E. Rohrbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10232 Royal St. Andrews Place Ijamsville, MD 21754 Dean Bogert, Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/06 Loudon Park Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licessee
Thomas Gregor ^{22 Name and Address of Facility} MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Posto perative infarction **Physician** 30 hours /Medical Due to (or as a consequence of): Examiner Signoidecton Perforated diverticulities Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Piabeks. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours To the Funeral 1 Contriving Physician: To the best of my knowledge death occurred at the time, date and bland, and due to the dause(a) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEC P-1085 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aug; Baltimore, MD 900 Caton Bashin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 13:35 2006 TON December 1 /Medical Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Kins Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**⊠**M 2□ F 77 Yrs. Director 074-22-6497 04/21/1929 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director DE New Castle Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene introducing them 23a or Important: If Item 27 is marked other than "natural" or Items 23a or Important: If Item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be 1 ence. 106 Hitching Post Drive 19803 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Du Pont Elementary/Secondary (0-12) College (1-4or 5+) Research Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Lewis Osborn Annalee Gilligan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Osborn/Wife 106 Hitching Post Drive Wilmington, DE 19803 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Dec 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2006 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 □ Yes 2 □ No 2 Accident Director: Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

IDNO

2006

31. Date filed (Month, Day, Year)

6:15 A,M.

DECEMBER

	s, P.C
N OCH	ecord
NORMA	Vital R
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	rision

			For State Registrar	State of Mar	yland /	-	ertment of H Tificate of L		_	giene Reg. No.	006	40036
		6	Decedent's Name (First, Middle, Last)					2. Date of De	ath	V	3. Time of Death
	Physicia /Medic		NORMAN WALT	CER OCH					Decemb	er 13,	2006	6:15 A. M
	Examin	- 14	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	n	4c. Cou	nty of Death	1
		N.	Stella Maris	7 Agg (In use least	h ivth do u	Timon	Lum If Under 24 Hrs.	8. Date of Bir		1timo	
	Funeral		5. Social Security Number 6. Se 217–18–1074	X	In yrs. last i	Yrs.	Months Days	Hours Min.	Oct. 1	iv, Year)	9. Birti Cot Mar	nplace (State or Foreign Intry) yland
	Director		Usual Residence of Decedent						OCL. 1	0, 192	rial	yrand
	ylanc now at		10a. State 10b. County	1	0c. City, To	own or Lo	cation					10d. Inside City Limits
	e Ma 3a-f s tified	Director	Maryland N/A		Balt	imor	e e					1 XYes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen		untry?
	ath w	ra	431 Kenneth Squa		:	140.1		1212	and Van an Na		.S.A.	ioan Indian
	ter de item iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1. ▼Yes 2 □ No.	er in U.S.	13. 1	Was Decedent of Hi f Yes, specify Cuba	in, Mexican, Puerl	to Rican, etc.)	, 17.	Black, White	
5	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:WW	ΊΙ	1	1 ☐ Yes 2 🌠 No	Specify:		Spe	ecify: Wh	ite
2-003p	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication	16	6a. Deced	dent's Usual Occupa	ation	rkina	16b. Kind o	f Business/I	ndustry
Ž	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			kind of work done o		King	D 1	D 11	
7	led w lygier her th	Co	47 F-Maria Nama (First Middle Lost)	5+ years		Во	ok Desigr	1er 18. Mother's Nar	no (Eiret Middle			ishing
and	l be fi	Be	17. Father's Name (<i>First, Middle, Last</i>) Conrad Oc	ah.				Katie	ne (First, Middle	Sulli	ŕ	
⋝	hould the mark mark	ဥ	19a. Informant's Name/Relationship (T		1	9b. Mailin	ng Address (Street a		ural Route Numb			ip Code) 17316
<u>8</u>	nd 2 sulth ar		Robert C. Och	(son)			Baltimore					
ē,	is 1 a of Hea Item othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place	i	Date	20c. Location		
E	Page nent c int: If		1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-	unt Crema	i i	-14-06	Baltin	ore.	Maryland
Saltimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	see		- 1 M	Name and Addres	Viedefeld	d Funera	1 Home	. Inc	
_	205 g		Deorge J. P	enan	<u> </u>		6500 York	c Road	Baltimor	e. Mar	vland	21212 Approximate
	9 4		23a. Part1. Enter the disease or comp shock, or heart failure. ist only c	ne cause on each line.	e death. D	o not ent	er the mode of dyin	g, such as cardia	c or respiratory a	irrest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HEPATOM		5\.						
	Examiner			Due to (or as a d	onsequenc	æ oi).						
E		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse of injury)	b. Due to (or as a c	onsequenc	ce of):						
d	cuted nd ransit	Examiner	that initiated events	C	-							
8/60,	e exe sian a urial-l	EX	resulting in death) Last	Due to (or as a c	consequenc	ce of):						
200	ficate be executed physician and s the burial-transit	dical		d								
×	leath certifi attending for use as	Ψ	IF FEMALE:	23c. If yes, outcome pf	pregnancy			-		23d	Date of deli	Verv
gox	death certif e attending d for use as	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1⊡Live birth 2 4⊡Pregnant at tir]Ectopic pregnancy] Other <i>(specify)</i>			200.	Month	Day Year
j.	y th	Physician/M	9 Unknown	9□Unknown								
S,	requires that een signed b nould be deta	by P	Part II. Other significant conditions co	entributing to death but	not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco use o	ontribute to	the cause of death?
ä	equire en siç ould b								1 🗆	Yes 2 □ N	o 3∏Pro	obably 4 Vunknown
Hecord	a SC	ıplet							24a. Was	psy	prior to c	topsy findings available completion of cause of
	Th pag	Completed								ormed?	death? 1 ☐ Yes	2 🗆 No
VITal	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	or:	ath (Check only			
0	yr sir	: To	1 ☐ Yes 2 🙀 No 27. Manner of Death	1 ☐ Inpatient		Outpatier b. Time of	IL 3 DOA	4 ☐ Nursing F	lome 5 Res			eify) HOSPICE
0	ding h. After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day)		Injury	Worl	k? Yes 2 □ No				
UIVISION	Atter r deal ector by the	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	- At home,	, farm, str	eet, factory, office				ımber or Ru	ral Route Number,
5	tal or s afte al Dir ed in l	Certification:	_	building, etc.				City or Town, State)				
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral		(Check only 2 Medical Exam	/sician: To the best of iner: On the basis of e	xamination	dge, deatl and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s) and , date and pla	l manner as ce, and due	stated. to the cause(s)
	thin 2 thin 2 the or the	Medical	29b. Signature and title of certifier	and manner state	·a.		29c. Licenso	e number		29d. Date si	ned (Month	n, Day, Year)
	FSF8		/12				74	3725			2/13/0	
	10		30. Name and address of person who	completed cause of dea	th (Item 23	a) (Type,		0/00		ı	11-10	
	10		DR. TARIO MAHMO				LLEY RD.	TIMONIU	M. MD 21	093		
233	Sta		31. Date filed (Month, Day, Year)	\$2. Registrar'	s Signature)			-,			
S.	Registr	ar	DEC 1 5 2006	Sie	No.	dies.						
I)L	488H 17 Day 1/2	r\O.1			- 4	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		artment of F			gienez () (16 40037
			Decedent's Name (First, Middle, Last)			7		2. Date of Dea	ath	3. Time of Death
	Physici		HRLENG	2		SWA	LD	Deceme		Year 10 30 AM
}	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Death		4c. County o	of Death
			904 Sunnybrook D	rive		Glen 1	Burnie		Anne	Arundel
	Funeral		Social Security Number 6. Sex	3 , ,		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year)	Birthplace (State or Foreign _ Country)
	Director		202 16 0120	M 2DXF 80	Yrs.	Working Bays	110010	May 4,	1926	Pennsylvania
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. Cin	y, Town or Lo	cation				10d. Inside City Limits
	Aaryi	ō	Maryland Anne Ari		Glen Bu					1 ☐ Yes 2 X No
	the N	ect	10e. Street and Number	inder (JICH DO	10f. Zip Code			10g. Citizen of Wh	
	3a or	Funeral Director	904 Sunnybrook	Drive			060		U.S.	
	death The 23	era		12. Was Decedent Ever in U.	S. 13. V	Was Decedent of H	ispanic Origin? (St	ecify Yes or No-		- American Indian,
9	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f show he Madical Exemiter must be notified at	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	,	f Yes, specify Cuba □ Yes 2⊠ No	n, Mexican, Puerto	Rican, etc.)	Black	, White, etc.
21215-0036	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:						MILLICE
5	"nat	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	tent's Usual Occup kind of work done DO NOT use retired	durina most of worl	king	16b. Kind of Bus	iness/Industry
7	within end	E C	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		gement	,,		Bank	ina
0 0	filed Hygid ther	ပို	17. Father's Name (First, Middle, Last)			8	18. Mother's Nam	e (First, Middle,	Maiden Sumame	
an	ld be ental ked o	To Be	E1mer	Fullmer				e Robb		,
Maryland	mar mar	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailin	g Address (Street	and Number or Rui	ral Route Numbe	er, City or Town, S	itate, Zip Code)
	nd 2 alth a 27 is		Christine England							ryland 21060
ē,	s 1 a f Hee item othe	1 3	20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place		Date		City or Town, State
Ë	Pages ment of I ant: if its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation _5 ☐ Other (Specify)			Crematory		5/2006	Baltimor	ce, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be natified at ODGs.		21. Signatur II Fureral Service License	DAridae		. Name and Addre				rvice, P.A. Maryland 21225
			23a. Part1. Enter the disease, or compli	cations that caused the death						Approximate
	D		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	() () -					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	000	001	MENTI	A		16ym2
	Examiner			Due to (or as a consequ	uence or);					9
Ι		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of).					
/	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó	en ar irial-t	Ä	resulting in death) Last	Due to (or as a consequ	uence of):					n i
8760,	ficate be executed physicien and s the burial-transit	dicai	ď							
ထ	ing pl	Med	IF FEMALE:							
Вох	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	déath 3	Ectopic pregnancy			23d. Date Monti	of delivery th Day Year
<u>.</u>	that the death certif ed by the attending detached for use a:	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (specify)			Work	n bay roan
Д.	that the		Part II. Other significant conditions con	tributing to death but not rest	ulting in the un	ndertving cause give	en in Part I	23e Did to	phacco use contrib	oute to the cause of death?
Records,	se us	d by		•		, ,,,				3 ☐ Probably 4 ☐ Unknown
Š	w requir been si should	ete						24a. Was	24h 144	and a state of the
Ä	The iav	Completed						autop	rmed? pri	ere autopsy findings available for to completion of cause of eath?
_		e Co	25. Was case referred to medical					-	The state of the s	☐Yes 2☐No
Vita	ysician: Is certific director,	o B	examiner?	ospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	Oth	26. Place of Deal	-	ne/ dence 6 ∐Other	- (0 1)
ō	Attending Physician: r death. sctor; After this certifici y the funeral director.		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injun	4 Idursing no		now injury occurred	
o U	nding th. r: Afte e fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No			
Division of	or Attendented of the Control of the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office				r or Rural Route Number,
	tal or A rs efter ei Dire ed in b)	Certification:	+ a riskinose	building, etc. (Specify				City or Tow	m, State)	
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinate)	ician: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and mann date and place, an	ner as stated. nd due to the cause(s)
	To the vithin 2. To the complet	Me	29b. Signature and title of certifier	11	7	29c. License	e number	01	29d. Date signed ((Month, Qay, Year)
			· when	1 7 T		27 [14636	0 1	Jecemb	in 11,2006
	6		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Print)	well	200 - 1	A per	(Month, Day, Year)
	T	•	31. Date filed (Month, Day, Year)	32. Aegistrar's Signal	tuler A	0	113 611	new N	16501	1000 1100 1100
	Sta Registr		DEC 1 5 20	106	5 A	344		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Parrott Jordan Elizabeth 12 08 2006 12:00p.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Pikesville Baltimore Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03 23 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2X F 216-18-7963 1906 **Director** 100 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. In the Maryland int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 3519 Denison Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black 3 □Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Afro American 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Clerical Newspaper 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Levingston Peach Jordan ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trace 101 Barren Ridge Road, Chester, Md 21619 William Parrott Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 12/13/06 Arbutus, Md Arbutus Memorial 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medicai Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) I□Yes 2□No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed? this certificate 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death. uneral Director: / 2 ☐ Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier

within 24 hours a To the Funeral I 2

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324Registrar's Signature

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Albert Earl Pokorny December 14, 2006 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day,
Dec. 2, Baltimore 8800 Walther Blud., Apt. 2016 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F 88 217-03-4884 Maruland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show It a Modical Examinant be notified at 1 ☐ Yes 2 No Director Parkville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 8800 Walther Blud., Apt. 2016 U.S.A. 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lt. Colonel U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Pokornu Antoinette Bartunek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blud., Apt. 2016, Parkville, MD 21234 of Health Marie Rose Pokornu (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ital
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Camp Chapel UMC Cem. 12/18/2006 Perry Hall, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Malignant Melanomo Physician 8 years /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 K No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier

attending physician and The law raquires that the death cartificate be axecuted Division of Vital Records, P.O. Box 68760, after death.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

completely filled in by the within 24 hours a To the Funeral I 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D59805 12/14/2006 llen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Month Day, Year)
DEC 15 4924 Campbell Blud #200 BALTIMORE MD 21236 32 Registrar's Signature 31. Date filed (Month, Day, DEC State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

06-09397 Janice Parker		Print in Black Indelible Ink. f Maryland / Department of He			9.
	1- For State Registrar	Certificate of De	eath	Reg. No.	2006 40041
Physician/ Medical Examine	Janice	Park	er	Date of Death Month Day December 10, 1	
	4a. Facility Name (if not institution, give the University Hospital		ity, Town, or Location of Death	40	c. County of Death
Funeral Director	5. Social Security Number 6. Sex 1 N Usual Residence of Decedent	M	Under 1 Year If Under 24Hrs, on the Days Hours Min.	8 Date of Birth(MM.	DD/YYYY) 9 Birthplace (State or Foreign Country) LA
ow any	10a. State 10b. County	10c. City, Town or Location			10d Inside City Limits 1 1 2 No
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene from "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number	11 Sykyc	Zip Code	10g. Citi	zen of What Country?
eath with the M items 23a or 2 ust be notified Ineral Dire	303 Kingst	12. Was Decedent Ever in U.S. 13. Was De	al784 cedent of Hispanic Origin? (Spec	ify Yes or No.	14. Race - American Indian, Black,
r death with the Maryland or items 23a or 28a-f sh must be notified at one Funeral Director	1 Never Married 2 Married	Armed Forces? If Yes, s	pecify Cuban, Mexican, Puerto Ri		White, etc.
2 hours afte "natural". Examiner	3 Vidowed 4 Divorced	highest grade completed) 16a. Decedent's Us	2 No specify: sual Occupation (Give kind of working life, DO NOT use retired		Specify: Kind of Business/Industry
5-0036 led within 72 hour tygiene other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	5 Teller	,	Banking
15-0036 filed within 7 ll Hygiene et d other than et the Medice e Comple			18.Mother's Name (F	ırst, Mıddle, Maiden	Surname)
2121, hould be fil nd Mental B is marked rite event, To Be		Pe, Print) 19b. Mailing Add	ress (Street and Number or Rur	al Route Number, C	ity or Town, State, Zip Code)
nore, MD 21215-0036 ages I and 2 should be filed within 72 int of Health and Mental Hygene it: If fitem 27 is marked other than other traumatic event, the Medical To Be Complet	20a. Method of Disposition	20b. Place of Disposition		Sylvesui Date 20c.	Location - City or Town, State
altimore, mit Pages t an epartment of Hea pportant: If iter jury or other tra	1 Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State crematory or other pl Mutro	remotory 12-	18-06	Balto, mD
Baltime permit Pag Department Important:	21. Signature of Fulleral Service License	22. Name	and Address of Facility 4M 1232 Mil	dalka D	Y JERUP, PA 18434
Physician /Medical	failus List only one cause on each		de of dying, such as cardiac or re	espiratory a rest, sho	Approximate Interval Between Onset and Death
xaminer	Office and Discharge Lands	ultiple Injuries ue to (or as a consequence of):			Bediii
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence of):			
ecuted and transit		ue to (or as a consequence of):			
S = 3		AMENDED 23c. If yes, outcome of pregnancy		122	d Data of data
Box 68760, e death certificate but the attending physical of or use as the but will oversician/Mec	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal de Pregnant at time of death 5 Other (d. Date of delivery Month Day Year
D. Box 68760, the death certificate be every the attending physician ched for use as the burial Physician/Medic	1 Yes 2 No 9 V Unknown	9 Unknown ontributing to death but not resulting in the under		23e Did tobacco	use contribute to the cause of death?
ords, P.O. Bo. w requires that the dead is been signed by the att should be detached for oleted by Physi		oral balling to death bat hot resulting in the distant	ying dadse given iii arti.		No 3 Probably 4 Unknown
Records, The law requires frate has been sig. page 2 should by Completed	l ———			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal Reccion: The lection the lector, page			26.Place of Death (Check only	1 Yes 2 N y one)	0 1 Yes 2 No
of Vital Physician: ter this certif eral director.	1 Yes 2 No	Spital: 1 Inpatient 2 ER/Outpatient 3 28a. Date of Injury 28b. Time of Injury	DOA Other Nursing F	d Describe how inju	
Division of Vital Records, P.O. all or Attending Physician: The law requires that the safter death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	1 Natural 5 Pending 2 ✓ Accident Investigation	Dec 9, 2006 2240 hrs	1 Yes 2 ✓ No Pa		out of car and was struck
Division of ¹ Division of ¹ Suprise or Attending Ph Borns after death Borns after death Borns after filled in by the funeral Certification: T	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fac (Specify) Local Street		f. Location (Street a or Town, State) 2 Kingston Cir., E	nd Number or Rural Route Number, City Idersburg, Md.
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri. Medical Certification: To Be Completed by Physician/Medi		 To the best of my knowledge, death occurred a on the basis of examination and/or investigation, in and manner stated. 			
Š	29b. Signifure and title of certifier Warnete Dr	elshill	29c License number O.C.M.E.		Date signed (Month, Day, Year) ember 10, 2006
3		stant Medical Examiner 111 Penn	Street, Baltimore, MD 21	201	,
State Registra		32. Registrar's Signature	i		
DHMH 17 Rev 1/2001	SPECIAL PROFESSIONS	ORIGINAL			

		1.	For State Registrar		State of M	larylar			of Health and of Death	d Mer	ntal Hygie Reg.	-2000	6 40041
Phy	sician		Decedent's Name (First, Middle	, Last)			nu.		2.0		Date of Death Month	Day Year	3. Time of Death
_	edical	_	GEORGE	<u>C.</u>				LLIP			CEMBER	6 2001	
Exa	iminer	4a	Facility Name (If not institution,	-			CENTER		own, or Location of De			4c. County of De	ath
		5		6. Sex			last birthday)	If Under 1			Date of Righ	0.8	rthology (State or Foreign
Fune Direc		0.	Sooral Soorally Hambor (JACK		1 2□F	- C	7 Yrs.			lin. (Date of Birth Month, Day, Ye	ar) 9.00	rthplace (State or Foreign Country)
70		Us	sual Residence of Decedent								ICV 13 I	19.11	1110
rylan	1		a. State 10b. County			10c. Ci	ty, Town or Loca	ation					10d. Inside City Limits
e Ma	1 5		MD				B	alti	more				1 Ares 2 No
ih th or 28	Director	10	e. Street and Number		\			10f. Zip C	Code		10g.	Citizen of What C	country?
ath w	9	1	115 Jynu	2000	2 Av	e 3,	-d Floor		2122	4			SA
er de	Funeral	11	. Marital Status		. Was Deceden Armed Forces	? _	J.S. 13. W	as Decede Yes, specif	ent of Hispanic Origin? fy Cuban, Mexican, Pu	(Specify erto Rica	Yes or No- in, etc.)	14. Race - Am Black, Wh	
36 rs aft	N V		1 Never Married 2 Marri 3 Widowed 4 Ø Norced	ed	1 ☐ Yes 2 Z If Yes, Give Year or Dates		1[☐Yes 2	19 No Specify:			Specify:	1 1 1
and 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. to other than "nature!", or Items 23a or 28a-1 show and the state of the st	pa		15. Decedent	's Educa			16a. Decede	nt's Usual	Occupation		16h	. Kind of Busines	uhite
	Completed	_	(Specify only highes		completed)	· F · \	(Give ki	nd of work NOT use	done during most of w	working	100	. Italia of odsiries	windustry
d 2121 filed within Hygiene.	E O		Elementary/Secondary (0-12)		College (1-4or	3+)	Tre	ck	Driver			Truc	k.
P H H	BeC		. Father's Name (First, Middle, L	ast)		1		.,		lame (Fir	st, Middle, Maid	len Sumame)	
should be not Mental or marked or	1	(reorgie /	N.		Phi	llips	5	Eve	lun		Love	2
Maryland 212. d 2 should be filed within the and Menta Hygiene. It is marked other then			a. Informant' ame/Relationsh	ір (Туре	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			Address (Street and Number or	Rbral Ro	ute Number, Cit	y or Town, State.	Zip Code)
C 48 CM 12		E	Isie D. F	hil	lips /	>iste	1	market in the second	quarius	Av.	c. Pula	n Bay,	FL 32909
		20	a. Method of Disposition 1 Definition 2 Definition	3 ⊟Ren	\ noval from State		Place of Disposi cemetery, crema			Date	20c.	Location - City o	r Town, State
Fag ment tant:	i		4 □ Donation 5 □ Other (Sp	ecity)		IN	Letro (Yer	notar12	-18	5-06 Ti	3a1to	MD
altimo permit. Page Deperment of Important: If	je je	21	. Signature of Funeral Service L	icensee	\mathcal{V}		22.	Name and	Address of acility				
403	OI .		Men	1/	ha	~1		AM	11339 W!	dva	1 px A	c. Jessus	PA 18434
			3a. Part1. Enter the disease, or shock or heart failure. List of	complica only one	tions that cause cause on each	id the deat line.	h. Do not enter	the mode	of dying, such as card	liac or res	spiratofy arrest,	·	Approximate Interval Between Onset and Death
Physici		di	mediate Cause (Final sease or condition sulting in death)	_ a	INTR	ACR	ANIAC	- 1	TEMORR	HA	BE		2 days
/Medic Examin			Salarig III Goddily		Due to (or a	s a consec	juence of):						/
	i i	Se	equentially list conditions, any, leading to immediate use. Enter Underlying	b	Due to (or a	s a consec	mence of):						
198 - 3	Examine	ca Ca	ause (Disease or injury				,,-						
760, 760, 60 be executed sicien and burial-transit	EX	re	at initiated events sulting in death) Last	С	Due to (or as	a consec	uence of):						
8760, ^C C cate be execu				d									
68 tiffical	Physician/Medical	-										1	
Box 6 eath certific attending p	N Z	1F 23	FEMALE: b. Was decedent pregnant	23c	. If yes, outcome 1□Live birth			ctopic preg	Spaney.			23d. Date of de	livery
o dear he att	Sicia		in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Pregnant a			Other (spec				Month	Day Year
P.O. hat the deby the detached	Ą	-	9 Unknown										
	۾	Pa	rt II. Other significant condition	ns contri	buting to death	but not res	ulting in the und	erlying cau	use given in Part I.				o the cause of death?
w require	Completed	1-								-	1 🗌 Yes	2 ∐ No 3 ∐ P	robably 4 Monknown
Sec law e law has t	ā	- _								- :	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
al Relation The Inches had been been been been been been been bee	S										performed 1 ☐ Yes 2 ☐ 1		s 2□ No
Of Vital Physicien: this certifice	Be	25	. Was case referred to medical examiner?	Hos	pital:				26. Place of D				
of Vi Physicial this certain direct	P.	27	1 Yes 2 No Manner of Death		1 ☑ Inpati 28a. Date of Inj		ER/Outpatient 28b. Time of					6 ☐Other (Spe	ecify)
Ision (tanding Figure 1) the funers	Ş	-	1 ☑Natural 5 ☐ Pending		(Month, Da	y Year)	Injury	M 200	c. Injury at Work? 1 ☐ Yes 2 ☐ No	200.	Describe how in	jury occurred	
Division of Vital Records, lor Attanding Physicien: The law requires taffer death. The control After this certificate has been signed by the funeral director, peec 2 should be a	fica		3 ☐ Suicide 6 ☐ Could n	ot be	28e. Place of In	iury - At h	ome, farm, stree			28f I	ocation (Street	and Number or B	ural Route Number.
Div after a Div din bit	Certification:		4 Homicide determin	180	building, e	tc. (Specil	y)	,,			City or Town, Sta		oral ricolo rambor,
To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	a C	29	a. Certifier 1 Certifying	Physic	ian: To the best	of my kno	wledge, death o	ccurred at	the time, date and pla	ce, and c	lue to the cause	(s) and manner a	s stated.
n 24 in Period	Medical		(Check only 2 Medical E	xamine	r: On the basis of and manner s	of examina	tion and/or inve	stigation, ir	n my opinion, death oc	curred at	the time, date a	and place, and du	e to the cause(s)
To th within To th	M	29	b. Signature and title of certifier	7		<.		29c. l	License number		29d. [Date signed (Mon	th, Day, Year)
				·V	W (F)	A Transaction of the Control of the	0	KES-000		DEC	EMBER	6, 2006
3		30	. Name and address of person w				n 23a) (Type, Pr	int)		. /	7 - / /		6, 2006 D 21224
- 6	7		Dr. Yazmin	Mo				steri	n Avenue	1 1	paltimo	ire, MI	1 4224
Reg	State istrar	31	Date filed (Month Day Year)	2006	92. Regist	rar's Signa	ture Appear	23					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Susan Therese Palombo 3:50 PM 2006 DECEMBER 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE GOOD SAMARITAN Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/15/195 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Months Days Hours Min 216 665 670 54 Yrs. Director Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Itama 23a or 28a-1 ehow any Injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore County 1 ☐ Yes 2 No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 6701 Highview Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes X内 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status XX Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Accounting Industry Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oswald V Palombo Bernadine R Steiner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadine R Palombo 6701 Highview Avenue Baltimore, Maryland 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery December 12 2006 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Sann 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS + RENAL FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed LIVER FAILURE Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical ALCOHOLIC CIRRHOSIS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l page 2 s 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) bound (GHUSH M.D.) 12/07/06 P19470

State Registrar

2006 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature



BALTIMORE .

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

GHOSH

			1 - For Registrar	State of I	Marylan				ealth a D <i>eath</i>	and M		giene Reg. No:		400	43
			1. Decedent's Name (First, Middle, La	st)	-						2. Date of Dea Month	ith Day	y Year	3. Time of [Death
	Physici /Medic		Margaret M. Plum	mer							12/11/			07:40	A M
}	Examin		4a. Facility Name (If not institution, giv				4b. City	Town, or	Location of	of Death			County of De		
			Anne Arundel Med			to an total at a 3		napol r 1 Year		24 Hrs	0.0-1		Anne A		
	Funeral		5. Social Security Number 6. S	i⊒M 2K∐F /.	Age (in yrs.	last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day 02/12/	n /, Year) / 1 O 1	1 (irthplace (State or Country) MD	Foreign
	Director		220-40-1599 Usual Residence of Decedent		71		l	L			02/12/	191.)	ш	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City	y Limits
	a-f st	ior	MD Anne Ar	undel	M	illers	ville	5						1 Tyes	2 ⊠ No
	or 28	Director	10e. Street and Number				10f. Zi	Code				-	izen of What C	Country?	
	ath w	ral	62 Rol Park					108					.S.A.		
	er de	Funeral	11. Marital Status	12. Was Decede Armed Force	s?		Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Orig n, Mexican	gin? (Spe i, Puerto	icify Yes or No- Rican, etc.)		 Race - Am Black, Wh 		
36	rs aft	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 🗒 Yes 2 If Yes, Give Year or Date			1 🗀 Yes	2 ⊠ No	Specify:				Specify:	white	
Ş	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madical Everili at mail be notillied at		15. Decedent's E	ducation		16a. Dece						16b. Ki	ind of Busines	s/Industry	
715	nin 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4)	or 5+)	(Give	kind of wo DO NOT t	ork done d ise retired	during most)	t of worki	ng				
21	d with giene er tha	E	11	- College (1-4-	51 5+7	Home	make	<u> </u>				O	wn Home	e	
5	al Hy al Hy d other	Be	17. Father's Name (First, Middle, Last,)							(First, Middle,		Sumame)		
yla	Ment Ment arked atic	2	Jesse Kifer						Mart	tha b	azenbak	ter			
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. itiem 27 is marked other than "natural", or items 23e or 28e-f show item traumatic event, I a Medical Ever it armait to refilled at		19a. Informant's Name/Relationship (1.		-				/ Route Numbe			Zip Code)	
a,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra ance.		Mrs. Judith A. W	yatt/daug		/698 Place of Dispo			e.;		idena, M	_	LLZZ cation - City o	r Town State	
סב	if ite		1 ₺ Burial 2 Crepmation 3		ute C	cemetery, crer	natory or	other plac					•		
븚	it. Perinter	1 3	* 4 □ Donation 5 □ Other (Special 21. Signature Fun al Service Licer				_		1al		4/2006			Home, PA	
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	76x		23a. Part1. Enter/the disease, or com	plications that cau	sed the deat									Approximate	
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on eac	5 1	lvo sep	200							Onset and De	eath
	Physician /Medical		disease or condition resulting in death)	a Due to (or	as a conseq		24.7							days	
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ő	e exe ian a urial-		resulting in death) Last	Due to (or	as a conseq	uence of);									
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		_ d											
9	n certific anding p use as		IF FEMALE:	23c. If yes, outcome	ma of proces	anav.									
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o.	that the de ed by the detached	ysic	1 □ Yes 2 ₺No 9 □ Unknown	9□ Unknow		leath 5L	1 Other (S)	oecily)							
<u>α</u>	that the	y Ph	Part II. Other significant conditions of	contributing to deat	h but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco u	ise contribute	to the cause of de	ath?
ds	uld be	d by									1 K	es 2[⊒No 3□F	Probably 4 Ur	nknown
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Re	9 4 9	Completed									autops	med?	death?	completion of cau s 2□ No	use of
Vital	icien: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only or	2X No	1 1 1 1 1	15 2 110	
	ys Si is	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Minp	atient 2 🗆	ER/Outpatier	nt 3 🗆 D	Othe	er: 4 □ Nu	rsing Hor	ne 5□Resid	ence 6	3 □Other (Sp	ecify)	
0 4	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I	njury Day Year)	28b. Time of		28c. Injury Work		2	28d. Describe h	ow injun	y occurred		
Si.	endir sath. or: Af he fu	atle	2 Accident investigation	n			М		Yes 2□N	No					
Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of	Injury - At he etc. (Specif	ome, larm, str ý)	eet, lactor	y, office		2	281. Location (S City or Town			Rural Route Numb	er,
	urs al urs al eral D			<u> </u>	4-6					- 1					
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	nysicien: To the be miner: On the basi and manner	s of examina	wieuge, death ition and/or in	vestigation	at the tim	ie, date and pinion, deat	u piace, a th occurre	ind due to the c ed at the time, d	ause(s) late and	and manner a place, and du	is stated. ie to the cause(s)	
	o the	Мес	001 001	3			29	c. License			2	9d. Date	e signed (Mor	ith, Day, Year)	
	- s - ō		> One	nd Berl	, rup			D	16057				12/11	12006	i
	رے		30. Name and address of person who	completed cause of	of death (Item	n 23a) (Type	Print)/		0	. 61	P' Mr	<u> </u>			
	5		Spord Bluk;	MU 200	1 med	real 1	enuh	iery		nah	100	Dr	. Sjoe	rd Beck,	MD
	Sta Registr	ite ar	30. Name and address of person who Science (Month, Day, Year) 31. Date filed (Month, Day, Year)	2006 32. 869	istrar's Signa	ature.	DE ALL							_	

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2 0 0 5										06	40044	
100	Physici		Decedent's Name (First, Middle, George		Α.	(Quives		2. Date of Dea Month 12	ath Day	Year 006	3. Time of Death 2:12p M
	/Medic Examin		4a. Facility Name (If not institution, 901 Cherry		ot. 3	361		imore		4c. County		
	Funeral Director		5. Social Security Number 229–14–2959 Usual Residence of Decedent	S. Sex 7. Age	85 (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 11 —6	-1921	9. Birthpla Counti	va.
	Maryland -f show fied at	tor	10a. State 10b. County	NA	10c. City	, Town or Lo Bali	cation Cimore				. 10	d. Inside City Limits 1 X Yes 2 □ No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 901 Cherry Hil	l Rd. Apt	. 36]	L	10f. Zip Code 21225			10g. Citizen of V U	Vhat Count	ry?
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	If Yes, Give		'	Was Decedent of Hi f Yes, specify Cuba I □ Yes 2[X]No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		e - America k, White, e	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ttal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed b	3√ Widowed 4 □ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Year or Dates: Education grade completed) College (1-4or 5	(Give kind of work done during most of working life. DO NOT use retired)						ısiness/Indu	
d 212	e filed within 7 al Hygiene. I other than "r vent, the Med	Be Com	7th grade 17. Father's Name (First, Middle, L.		+)	T	ruck Driv		me (First, Middle,	Vario		
larylar	Benjamin K. Quiv								ıral Route Numbe			Code)
	교육등학		Shirley Cumming 20a. Method of Disposition 1 ByBurial 2 Cremation		20b. Pl	lace of Dispo emetery, crer	05 Madiso sition (Name of matory or other plac	e)	Date	20c. Location -	City or Tov	
Baltimore,	permit. Pages 1 an Department of Hea Important: If item 2 any injury or other once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		Ga	22	n Forest Name and Addres	s of Facility	March F	Owings .H. East	t	s, Md 1202
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	complications that caused nly one cause on each lin		or respiratory ar			Approximate Interval Between Onset and Death			
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	uence of):	B	20300				
	scuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.								
8760,	cate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as	a consequ	Jence or):						
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3]Ectopic pregnancy] Other <i>(specify)</i>			23d. Dat	te of deliver	y Day Year
rds, P.	quires that in signed by uld be deta	by	Part II. Other significant condition	ns contributing to death bu	ıt not resu	ulting in the u	nderlying cause give	en in Part I.				e cause of death?
Vital Records,		Completed							24a. Was autop perfo 1∐ Yes	rmed?	prior to com death?	sy findings available pletion of cause of 2□ No
or Vita	Physician: The rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 i	ER/Outpatier		er: 4 🗆 Nursing F	ath (Check only o		er (Specify,)
S 1 □ Natural 5 □ Pending (Month, Day Year) Injury Work?									now injury occurr			
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	1 1	4 ☐ Homicide determin		c. (Specify	v) 		ne date and place	City or Tou			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical E	xaminer: On the basis of and manner sta	examina	tion and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and place,	and due to	the cause(s)
	0/		30. Name and address of person w	/ho.completed cause of d	VITY eath (Item	1 N (Type,	D2\	4148		PERDY	BEL	12,2006
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	W	350		COGEN	U AR	16 B.	112 30	71215
	Regist	State Registrar DEC 1 5 2006 32. Registrar's Signature										

Please Type or Print in Black Indelible Ink 06-09122 Maryland / Department of Health and Me Richard Rideout Hygiene 40045 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month November 30, 2006 2006 hrs **Medical Examiner** Richard Rideout 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Baltimore 2554 W. Fairmount Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours Director Country) Maryland 1 X M 2 Yrs 214-68-3838 48 1957 Dec 4. Usual Residence of Deceden 10a. State 10d. Inside City Limits 10c. City, Town or Location 10b County X Yes 2 No MD Baltimore 28a-f show death with the Maryland Director 10g. Citizen of What Country s 23a or 28a-f e notified at o 10f Zip Code 10e. Street and Number 4542 Manorview Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black 11 Marital Status 12. Was Decedent Ever in U.S. must be White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes Black f Yes, Give Year 1 Yes 2 X No specify: white ģ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other than " matic event, the Medical Baltimore, MD 21215-0036 . . and 2 should be filed within tment of Health and Mental Hygiene stant: If liten 27 is marked on yr other trainer. 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) unk Be Richard W. Rideout 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1VelmantMaDiRilard (Rideout/spouse Vilma Rideout/spouse 4542 Manorview Road Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date crematory or other place) Burial 2 Cremation 3 Removal from State Important: I 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Signature of Euneral Service Licensee irector timore, MD 21201

e mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the dis Physician ure. List only one cause on each line Between Onset and /Medical Death Heroin and cocaine intoxication Immedia - Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) #14&19a Per Inf G862 12/15/06 Jh Physician/Medical AMENDED X UNPENDED sician perME. g862. 12/18/06 TT #23a,27,28a-f Division of Vital Records, P.O. Box 68760. IF FEMALE: 23d Date of delivery ending physuse as the b 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Day 3 Ectopic pregnancy Month Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No Yes 2 No 1 🗸 Yes this certificate 26 Place of Death (Check only one) 25. Was case referred to medica Be Other₄ DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 2 ို ✓ Yes 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred After 28b. Time of Injury 28c Injury at Work? 27. Manner of Death To the Hospital or Attending I within 24 hours after death. To the Funeral Director: Afte Certification: Natural Yes 2 X No 5 Pending the Fnd 11/30/2006 Fnd 7:50 pm unknown Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2554 W. Fairmount Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide (Specify) Homicide Baltimore. 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 1, 2006 30 Name and address of person who completed cause of death (Item 23a

DHMH 17 Rev 1/2001 OCMF 2006

State

Registra

111 Penn Street, Baltimore, MD 21201

Pamela E. Southall, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year)

DEC

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene			1
otate of marytana, population of floater and more in give	100	~	- 1

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** Adam Reed 2006 10:10 A Joseph 12, Dec /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1825 Portship Road Baltimore Co. Dundalk 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral 1√3**M 2□ F Months Days Hours Yrs. 83 Director 214-18-6768 March 28,1923 | Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Dundalk Directo Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 1825 Portship Road United States filed within 72 hours after death Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 🛠 🖾 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White δ WWIT 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banker Banking 12 Years other i 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be marked Marie Lutz Adam A. Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health and Important: If Item 27 is m any Injury or other traum once. Mrs. Judith A. Reed (Wife) 1825 Portship Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 12/16/2006 Elkridge, Laryland 22. Name and Address of Facility permit. ture of Funeral Service Licenser Duda-Ruck Funeral Home of Dundalk, Inc. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE Physician DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificete 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0061480 06 emo Jasmin 30. Name and address of person who completed cause of death (I w 23a) (Type, Print) Blud Buts MD 4520 Lans ampbe 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 2006 5 Registrar

			State of Maryland	d / Department of Health and Me Certificate of Death		2000 40041
-			Registrar 1. Decedent's Name (First, Middle, Last)		Reg. N 2. Date of Death	o. 3. Time of Death
	Physicia		Eleanor J. Reed		Month 14	2006 15:07 PM
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			Franklin Sayare Hospi	TRI COSECUALE ast birthday) If Under 1 Year If Under 24 Hrs.	2 7 (8)	BACTIMORE
	Funeral Director		242 22 5046		8. Date of Birth (Month, Day, Year DEC • 7 , 19	9. Birthplace (State or Foreign Country) 34 MAryland
	σ		Usual Residence of Decedent			
	arylan show	_	10a. State 10b. County 10c. City, MD Baltimore	Town or Location Middle River		10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Director	10e. Street and Number	10f. Zip Code	10a. C	itizen of What Country?
	death with the Maryland me 23a or 28a-f show	ā	6905 Harewood Park Drive	21220		SA
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	rify Yes or No-	14. Race - American Indian, Black, White, etc.
20	or ite	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
Ş	filed within 72 hours after Hygiene. ther than "natural", or ite int, the Medical Expuritie		15. Decedent's Education	16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
2	hin 72 P. In "na Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)		l
V	ygiene ygiene ner tha	Con	12th	Homemaker		own home
	ntal H od oth	Be	17. Father's Name (First, Middle, Last) HArold Koerner		First, Middle, Maide) Grazoni	
Ž	should nd Mer marke umatic	ို	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural		
Z	and 2 sealth ar		Wanda Reed /daughter	6905 Harewood Park	Drive B	alto. MD 21220
ย์	- I 5 5		of During Commercian C	emetery, crematory or other place)		Location - City or Town, State
ашшо	Pages tment of tant: if it		4 □Donation 5 □Other (Specify) HOJ	lly Hill Cemetery 12,		
D D	permit. Pages Department of Important: If i eny Injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 300 Connelly Funera		ve. Balto. MD
			23a. Parti. Ther the disease, ir compil later is that cause it he death shock, ir heart failure. List only ric cause on each line.	The state of the s		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death)			
	Lxammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Au t	espiratory distre	22 2 AV	ed come
	per lisus	Examiner	cause. Enter Underlying Cause (Disease or injury	,		
Ď.	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Еха	resulting in death) Last Due to (or as a consequ	rence of);		
00/g	ate be	dical	d			
Q X	certific ding p	•	IF FEMALE: 23c. If yes, outcome of pregnar	псу		23d. Date of delivery
ZO D	death	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\triangle Vas. 2 \) \(\triangle No. \) 4 \(\triangle Pregnant at time of de	death 3 ☐ Ectopic pregnancy		Month Day Year
,	at the by the tacher	hys	9 ☐ Unknown		-	
'n,	law requires that the es been signed by th 2 should be detache	٥	Part II. Other significant conditions contributing to death but not resu	Ilting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
ecords	requi	eted	T P			
	hes hes	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
VIII K	sicien: Th certificate rector, pag	a	25. Was case referred to medical	26. Place of Death	(Check only one)	lo 1 🗆 Yes 🔉 No
	Physicien: this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Npatient 2 1	ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence	6 ☐ Other (Specify)
n or	ing Pl		27. Manner of Death 1★Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	Injury Work?	8d. Describe how in	ury occurred
DIVISION	Attending Physicien: or death. ector: After this certific by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At ho	M 1 Yes 2 No	8f. Location (Street a	and Number or Rural Route Number,
2	al or A	Certification:	4 Homicide determined building, etc. (Specify	")	City or Town, Sta	ite)
	To the Hospital or Attending Phys within 24 hours eiter death. To the Funerel Director: After this completely filled in by the funeral di	edical ((Check only 2 Medical Examiner: On the basis of examinat	wledge, death occurred at the time, date and place, a tion and/or investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	ithin 2 of the I	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, Day, Year)
}	F ≯ F 8		· C26	064405	? 12	2.15-06
	12		30. Name and address of berson who completed cause of death (Item	23a) (Type, Print)	, ,	
			DR AJAG BEHALI 9000 Fr4. 31. Date filed (Month, Day, Year) 32. Registrar's Signal	23a) (Type, Print) ELKIII SQUARE DRIVE BA	(timore	MD 21231
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signal	M. Aread B		
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ames Rytina		State of Maryland / Department of Health and Mental Hy 1-For State Registrar Certificate of Death		teg. No. 2	006 4004
Physici Vledical Exami			2 Date of Dea Month Decembe		3. Time of Death 1050 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 610 Northpoint Road Dundalk	-	4c. Count	y of Death ore County
Funeral Director		5. Social Security Number Output Out	8. Date of Bi		yy) 9. Birthplace (State or Foreign Country) Maryland
Maryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 Yes 2 XNo
eath with the Maryland items 23a or 28a-f sho ist be notified at once.	Funeral Director	10e. Street and Number 610 Northpoint Road 11. Marital Status 1 Never Married 2 Married 2 Married 3 Married 4 Married Forces? 10f. Zip Code 21222 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No		,
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	ompleted by Fu	1 Yes 2 X No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		Specify	White Business/Industry
21215-0036 hould be filed within 72 Id Mental Hygiene is marked other than '	To Be Com	11 Dispatcher 17. Father's Name (First, Middle, Last) James Frank Rytina, Sr. 19a. Informant's Name/Relationship (Type, Print) Dispatcher 18. Mother's Name (Mary Ka	atherir	Maiden Surnam ne Jones	5
ore, Nes I and of Health	ř	James Frank Rytina, III (Son) 414 Machias Place Mic 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	ddle Ri	ver, Ma	aryland 21220 arcity or Town, State
Baltimore, permit Pages I a Department of He Important: If ite		21. Signature of Funeral Service Licensee 1 Ruchael C. Jalhan, Sr. 22. Name and Address of Facility Bruzdzinski Funeral 1407 Old Eastern Av	/14 06 L Home Venue	PA Essex.	more, Maryland Maryland 21221
Physician /Medical Examiner		23a. Part I. Enter the disease, of completations that caused the death. Do not enter the mode of dying, such as cardiac or a failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	respiratory arr	est, shock, or h	eart Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last			
to, e be executed ysician and burial - transit	edical	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	су	23d. Date of Month	of delivery Day Year
rds, P.O. requires that the been signed by rould be detach	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcoholism	1 Yes	2 No 3	iribute to the cause of death? Probably 4 Unknown Were autopsy findings available
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should be	Be Completed	25. Was case referred to medical 26. Place of Death (Check on examiner?	1 🗸 Yes	med?	prior to completion of cause of death? 1 Ves 2 No
ion of Vit ttending Physic leath tor: After this the funeral dire	입	1 Yes 2 No Trospital 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing		Residence 6	Other Scene
Division e Hospital or Attendir 124 hours after death e Funeral Director: A	al Certification:	3 Suicide 6 Could not be determined 28e Place of Injury - At home, farm, street, factory, office building, etc. 29 (Specify) 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	or Town, S	tate) e(s) and manne	
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated 29b. Signature and title of certifier 29c. License number O.C.M.E.	he time, date i		ned (Month, Day, Year)
5		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 5 2006			
DHMH 17 Rev 1/	Y. B.	Comment			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day 123 **Physician** Mary Helen Ricker promber 13 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/29/1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 25F 216-24-6564 78 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar mines. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 ☐ Yes 2 XNo Director Baltimore Essex Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 285 Montrose Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 XWidowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Control 10 Polv Seal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James William Weyant Margaret McMillin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Avon Avenue, Dundalk, Maryland 21222 Susan Elaine Szymezak (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/17/2006 | Baltimore, Maryland Gardens Of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. ulure of Poweral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Exercisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease u condition resulting in a ath) Physician /Medical Due to (or as a consequence of) Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 4 ☐ Pregnant at time of death 1 Yes 1 No Ö 9 Unknown signed by to ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Tyes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was an page 2 s autopsy performed? this certificate 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No **1** □ Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 ₩ātural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Year. Registrar

State of Maryland / Department of Health and Mental Hygiefie [] [] 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:45 P RICE December 2006 RALPH FREDERICK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 26888 Johnson Creek Road Crisfield Somerset 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1X M 2 □ F Days Yrs. Director 339-18-1043 August 16,1922 Michigan Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is markad other than "natural", or items 23a or 28a-f show other traumatic avant, If a Medical Exertinast be notified at 1 ☐ Yes 2 ☑ No Director Somerset Crisfield Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 26888 Johnson Creek Road 21817 USA 12. Was Decedent Ever in U.S. Armed Forces? 1½Tyes 2 □ No World If Yes, Give Year or DatesWar II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel', or itan any injury or other traumatic event, the Medical Exertilist once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: White 3℃Vidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archibald Rice Betty Schrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 266.75 Johnson Crook 2000 - Crisfield, Maryland 2161.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State David Macneal (Son) 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Springhill Memory Gardens 12/9/06 Hebron, Maryland 21. Signature of Funeral Service License Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final CORDNARD DISEASE Physician MASSAN 7 EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that in the last of the last o Due to (or as a consequence of): requires that the death certificate be executed signed by the attending physician and depended for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Nown ITRM REGURGITATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10062196 DECEMBER 7, 2008 nt) SOUTH BIVISION SNITE B SMISHIRTY D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 UTIERREZ 1415 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State DEC 1 5 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per inf 9862 12-28-06 vt. State of Maryland Poepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Do C Catherine Elizabeth Rutkowski 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis - Loch Raven Balto. Balto. | If Under 14 Hrs. | S. Date of Birth (Months, Day, Year) | June 23, 19 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 X F Yrs. 217-22-3559 Director 1921 Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 289-f ehov 1X Yes 2 □ No **Funeral Director** MD Baltimore with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2927 Fait Avenue 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ imore, Maryland 21215-0036 1 ☐ Yes 2 XXVo Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10th grade Homemaker Own Home Pages 1 and 2 should be filed nent of Health and Mental Hygi ant: If item 27 ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Rubeling Marie Bridget Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Rutkowski 7 Spruce Circle, Shiremanstown, PA 17011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State I Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If eny injury or once. Sacred Heart of Jesus Dec 16, 2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue, Baltimore, MD 23a. Part anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Sacral tectod **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No 2 No 1 Yes 1□ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

within 24 hours after death.

To the Funeret Director: All completely filled in by the fu o the Hospitel

> State Registrar

31. Date filed (Month D

29b. Signature and little of certifier

0 0/ 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4001

2006

29c. License number

			_ For	State of Maryland	d / Depa	artment of H	lealth and N	•	•	1	
			1 - State Registrar		Cei	rtificate of	Death		g. No.	40002	
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yee	3. Time of Death	
	/Medic			RMAN ROSE				December	12, 2006	7:25P ^M	
7	Examir	ner	4a. Facility Name (If not institution, give s				r Location of Death		4c. County of Death		
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	Funeral		5. Sociat Security Number 6. Sex	0-	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, February 2	(gar)	irthplace (State or Foreign Country) WYORK	
	Director		475-10-6153	^{1 M 2} XX 90	115.			rebruary 2	3,1910 146	ew York	
	land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	Mary	ğ	Maryland N/A	Ra	altimo	re				YXXYes 2 □ No	
	28s	rec	10e. Street and Number	, DC	I CIMO	10f. Zip Code		10	g. Citizen of What (
	72 hours after death with the Maryland Instural', or Items 23s or 28s-1 show Mical Exertiner must be notified at	Funeral Director	401 Gittings Avenue	e		2121	2		USA	•	
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<u></u>		၉	Charles Villemann					a Gassman			
Maryland 21215-0036	~ ~ = =		19a. Informant's Name/Relationship (Ty. John Marcus Rose	pe, Print) Son					City or Town, State		
	s 1 and if Health Item 27 other tr							-	Maryland		
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 Cremation 3 R	emova nom state		sition (Name of natory or other plac	1		Oc. Location - City of		
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			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	oations that caused the death te cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
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1	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):			-			
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<u> </u>	\$ 5 8	4	Part II. Other significant conditions con	tributing to death but not resu	ilting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?	
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Re	The lavelete has	ဋ						autopsy perform	prior to death?	completion of cause of	
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io u	Attending ir death. ector: After by the fune	i i	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No				
N S	or Attendi efter death. Director: A d in by the fu	HC	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of tnjury - At ho	me, farm, str	eet, factory, office		28f. Location (Stre	et and Number or I	Rural Route Number,	
ā	s efte	Certification:	→ □ Homida	building, etc. (Specify	,			City or Town,	J(818)		
	To the Hospital of within 24 hours eff To the Funeral Discompletely filled in	;ai (29a. Certifier 1 Cartifying Phys	sician: To the best of my know	wledge, death	occurred at the tin	ne, date and place,	and due to the cau	se(s) and manner a	as stated.	
	he Hin 24 he Fu	edicai	(Check only 2 Medical Examination)	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death occur	red at the time, dat	e and place, and du	e to the cause(s)	
	To To t	Σ	29b. Signature and title of certifier	1./1		29c. Licens			d. Date signed (Mor		
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	0		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	0 -1 2	. 7			
_	T		Jason Black,	6565 NOITE		ires St	, Svite 1	09, 104	-son Mc	21204	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signat	ure						
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9, 2006 3:57 P^{M} December Muriel Louise Rose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 🔀 November 20, 1915 | Illinois 345-34-4145 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Maryland | Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 14901 Bristol Hill Lane United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Cramer Marie Weldon ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) Carl Rose / Son 14901 Bristol Hill Lane, Silver Spring, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 14, 2006 Bethesda, Maryland 4 Donation 5 Dother (Specify) 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service-Licensee M01305 Robert A. Pumphrey Funeral Home/Rock 300 West Montgomery Avenue, Rockvil 23a. Part1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Renal Failure /Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit End Stage Dementia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 💹 No Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 1 Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ MOther (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 💢 No this After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

State Registrar

Cynthia M. Williams, 31. Date filed (Month, Day, Year) DEC 15

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Road, Rockville, Maryland 20855

29c. License number

H0058032

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 12,2006 2:05PM Diana Marie Richardson 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 1385 Teaberry Lane Severn Anne Arundel 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday Days 1 □ M 2 🔀 F 79 Nov. PΑ 220-20-5457 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1385 Teaberry Lane 21144 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No White Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Court Reporter Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nicholas Carpellotti Clara DeCosmo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8073 Foxwell Road Glen Burnie MD 21061 Mrs. Joan Shores /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 29. 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 2006 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD 21061 MO1357 ancus 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocard unknown Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health at
important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

MD

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

certificate be executed Division or Vital Records, P.O. Box 68760

or Attending

the Hospital

Examiner attending physician and for use as the burial-tran Physician/Medical signed by t 1 be detach Completed by Jas page funeral director, Be 2 this To the russymmer death.

Within 24 hours after death.

To the Funeral Director: After this Certification:

_	Sequentially list conditions,	D.	41	mphoma				· yew
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of): Due to (or as a consequence of):		16.1				
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown			c pregnancy (specify)			23d. Date of deli Month	ivery Day Year
Completed by Ph	Part II. Other significant conditions	s contributing to death but not resulting in the und	erlyin	g cause given in Part I.	1 24a. Wa	Yes s an opsy formed	2 No 3 Pro	the cause of death? obably 4 Unknown itopsy findings available completion of cause of
Be	25. Was case referred to medical			26. Place of Deat	th (Check only	one)		
0	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□	DOA Other: 4 Nursing Ho	ome 5 Re	sidence	6 □Other (Spec	cify)
ation: T	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28b. Time of 28c. Injury at 28d. Describe how inj					
Medical Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of injury - At home, farm, stree building, etc. (Specify)	t, fac	tory, office	28f. Location City or T	(Street own, St	and Number or Ru ate)	ıral Route Number,
dical	29a. Certifier (Check only one)	Physician: To the best of my knowledge, death of aminer: On the basis of examination and/or inve- and manner stated.	occur	red at the time, date and place, tion, in my opinion, death occu	, and due to the rred at the tim	e cause e, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
9	29b. Signature and title of certifier	(20)		29c. License number		29d. l	Date signed (Mont	h. Dav. Year)

12 State

Registrar

31. Date filed (Month, Day, Year)

Donna Chambers MD

29b. Signature and title of certifier

2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 112 Annapolis MD 21401

D48101

29d. Date signed (Month, Day, Year) Decemberi4,2006

06-09384

George Chinghsin Shih

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2006 40055

		Registrar		Cei	rtificate d	of Dea	ith			Re	eg. No.		
Physicia ledical Examin	n/	1. Decedent's Name (First, Middle, L George Chinghs								Date of Dea Month Decembe			3. Time of Death 1045 hrs
		4a. Facility Name (if not institution, g 6214 Breezewood Court	give street and number	er)			Town, or Lo	ocation of	Death		4c. County o		's
Funeral		5. Social Security Number 6.		Age (In yrs. I	ast birthday)	If Un	der 1 Year	If Under Hours	24Hrs.		th(MM/DD/YYYY)		hplace (State or
Director		356-46-7665 12 Usual Residence of Decedent	M 2 F		47 Y		IIIS Days	Hours	WIII I.	Aug 9	, 1959		intry)
r any	ŀ	10a State 10b. County		10c. City	Town or Loca		·						10d. Inside City Limits
daryland 28a-f show d at once.	គ្ន	Maryland Prince 10e. Street and Number	George's		Green		ip Code			11	0g. Citizen of Wh	at Coun	1 Yes 2 No
th the Mar. 23a or 28a notified at	Director	6214 Breezwood	Court			101. 2	2077	70			USA	at Court	uy.
h with t	ᇹ	11. Marital Status	12. Was Decede					anic Origin		ify Yes or No can. etc.)			can Indian, Black,
	Fu	1 Never Married 2 Married 3 Widowed 4 X Divorce	1 Yes	2 X No	1		2X No				Specify:	Asi	an
hours al natural	ed by	15. Decedent's Education (Specify			16a Decede		al Occupatio orking life. E				16b. Kind of Bus	siness/Ir	ndustry
5-0036 led within 72 l Hygiene other than ",	mpleted	Elementary/Secondary (0-12)	College (1-4 o	or 5+)			Worke				N/	'A	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica	ပျ	17. Father's Name (First, Middle, La	est)				18				Maiden Surname)		-
212' ald be Mental marke event	o Be	James Shih 19a Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addre	ss (Street a			Feng at Route Nun	nber, City or Towr	, State.	Zip Code)
MD 2 rd 2 shou Ulth and I m 27 is r	-1	James Shih, F									omac, MD		
imore, MD 2121 Pages I and 2 should be finent of Health and Mental I and I friem 27 is marked or other traumatic event,	Ī	20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
Baltimore, permit Pages I an Department of Hea Important: If iter		4 Donation 5 Other Spec	eify:		ro Cre				12/1	4/06	Baltimo	re,	Maryland
Balt permit Depart Import	- 1	21 Signature of Funeral Service Lic Thomas Gregor	Monoo S			rema OO F	tion S	SOCIE	ty 0	f Mary	land, Ir	nc.	nd 21228
Physician	1	23a. Part I. Enter the disease, or confailure. List only one cause on	mplications that caus	ed the death	. Do not enter	the mode	e of dying, si	uch as car	rdiac or re	espiratory arr	est, shock, or hea	rt	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Atherosc			ascula	ar dise	ase ar	nd que	etiapine	intoxicat	ion	Death
		Sequentially list conditions,	b										
	miner	(Disease or injury that initiated	Due to (or as a cor										
	Exa	events resulting in death) Last	Due to (or as a cold.	nsequence o	or):						. <u>.</u>		
760, cate be executed physician and the burial - transit	edica	YUNPENDED			,28a-f,	perME	1/2/2	007 g8	363 TI				
as as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo		2 🔲 F	etal deat	h 3 [Ectopic	pregnanc	у	23d. Date of Month		ay Year
Box 6	ysici	1 Yes 2 No 9 Unkno		at time of de	eath 5 (Other (Sp	pecify)						
P.O. Bees that the designed by the	by Phys	Part II. Other significant condition	ns contributing to de	eath but not r	esulting in the	underlyii	ng cause giv	en in Parl	t I.				he cause of death?
ords, P.C										1 Yes			opsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been so led in by the funeral director, page 2 should be	Completed									autop perfo 1 Yes	rm <u>ed</u> ? d	rior to co eath? ✔ Ye:	ompletion of cause of
Vital Rec		25. Was case referred to medical					26 Place o	of Death (0	Check onl		2 110	- 10.	2 110
Vita nysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2	R/Outpatie	nt 3	DOA C	ther ₄	Nursing I		Residence 6	and .	Scene
n of ling Pl After funera	L'id	27. Manner of Death 1 Natural 5 Pending	28a, Date of I (Month, Da	Injury ıy,Year)	28b. Time o	f Injury	28c. Injury		No.		how injury occurre	ed	
Sior Attence death ector: by the	Cati	2 Accident Investig	ation Fnd 12/9		Fnd 10:			es 2 X I		ngested	drug	r or Rur	al Route Number City
Divis Hospital or A 24 hours after Funeral Dire	Certification	3 Suicide 6 X Could n 4 Homicide determi	not be	House_	one, ram, sa	cci, iacio	y, omee 20	ildirig, ctc		or Town, S reenbel	State)6214 Br t, MD	eeze	wood Ct. #103
	Medical C		sician: To the best of ner: On the basis of e	xamination a					ce, and du	e to the caus	se(s) and manner	as state	d.
23	Me	29b. Signature and title of certifier	and manner state	=u		2	9c. License	number		-	29d. Date signe	d (Mon	th, Day, Year)
. 63		Maryone V	me Shu	l			O.C.M	I.E.			December	10, 20	06
S.		30. Name and address of person whe Margarita Korell MD.	Assistant Medic	al Examir	ner 111	Penn S	treet, Ba	Itimore,	MD 21	201			
Sta Regist		31. Date filed (Month, Day, Year)	32. Regis	strar's Signat	ure	ask.	e						
DHMH 17 Rev 1/20		BEG ! 3 5003 Jakes 12 19											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Name (First, Middle, Last) Month Day Year Physician 08:14 PM DEC 0 7 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 143-30-498 Usual Residence of Decedent 1 M 2 XF Director 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Exeminer must be notified at 1 Mes 2 No Director mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō SA Iteme 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify. Specify: Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Importent: if Item 27 ie marked other then "na any injury or other traumatic event and once. College (1-4or 5+) mestic 18. Mother's Name (First, Middle, Maiden Sumame) 1Z. Father's Name (First, Middle, Last, Be 19b. Mailing Address (Street and Number or Rural Route Number, City of L 19a. Informant's Name/Relationship (Type, Print) Creary S 20a. Method of Disposition Alaska Ob. Place of Disposition (Name of cometery, crematory or other) 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BaltoMD 213 1/ 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dyles, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA ASPIRATION Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner o the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by SMALL BOWEL OBSTRUC 1 Yes 2 No 3 Probably 4 Unknown FAILURE RENAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2□No Yes After this certific funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury **U**⊒Natural 5 Pending 2 No death. investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 000 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 5601 LOCH RAVEN BLVD , BALTIMORE , MD 21239 SOIN 31. Date filed (Month, Day, Year) 32. gistrar's Signature State 15 2006 Registra

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SHIFMAN, DOLORE

ORIGINAL

			1 - State of State of Registrar	Maryland /		rtment of He tificate of D		Mental Hy	giene	06	40057
	D		Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		Helen Mary Smith					Decemb			11:50 a ^M
	Examin		4a. Facility Name (If not institution, give street and num			4b. City, Town, or L	ocation of Death		4c. County	of Death	
			Greater Baltimore Medic 5. Social Security Number 6. Sex	cal Center 7. Age (In yrs. last b		Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Bi		imore	
	Funeral Director		213-12-7922 1□ M 2対F	83	Yrs.	Months Days	Hours Min.	03424-1	23 ear)	Mary]	
1	ס		Usual Residence of Decedent							TIMI y I	and
	arylar show	_	Maryland N/A	10c. City, To	wn or Lo	Baltimore				11	0d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Director									1 ∑ Yes 2 ☐ No
	with t	Ď	10e. Street and Number 6205 Marietta Avenue			10f. Zip Code	21214		10g. Citizen of \		.try?
2	death ms 23	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S.	13. V	Vas Decedent of Hisp Yes, specify Cuban,		pecify Yes or No		e - Americ	an Indian,
W	or Itan	Ē	1 Never Married 2 Married 1 ☐ Yes	2 🔀 No				Rican, etc.)		ck, White, e	etc.
四岛	ours arel',	d by	3 Widowed 4 Divorced If Yes, Give Year or Da	tes:		Yes 2XNo	Specify:		Specify	/:	White
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70	Hygi other	Be Co	17. Father's Name (First, Middle, Last)			1	8. Mother's Nam	e (First, Middle	, Maiden Suman		
-tan	uld be Menta rrked ric ev	To B	Frank Bojarski				Mary	Lukes			
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depentment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other treumatic event, the Medical Evanticer must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Nelson E. Smith – Husband	19		g Address <i>(Street an</i> Marietta Av			er, City or Town, Maryland		Code)
∑ ore,	of Hea		20a. Method of Disposition	comot		sition (Name of natory or other place)		Date	20c. Location -		wn, State
altimo	Pag ment ant: I		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	Morela	nd Me	morial Park	12-16	-2006	Parkville	e, Mar	yland
3alt	permit. Depert Import any in		21. Signatury if Funeral Service Licensee			Name and Address			larford Roa		
	705 # O		Charles of Mines of	ward the darkh. D		eonard J. Ru			ore, Mary	land 2	
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<u>a</u>	n: Th licete r, pag							1 ☐ Yes	2) No 1	Yes	2 🗆 No
Χit	sicial certii irecto	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 🕱 No Hospital:	patient 2 ☐ ER/C		Othor	26. Place of Deat	- X			
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ion	ath. r: Aft	atlo	1 Natural 5 Pending (Montr 2 Accident Investigation	, Day rear)	Injury		s 2 No				
Division of Vital Records, P.O. Box	or Attending Physician: The law requires that the death certificate death. Director: Atter this certificate hes been signed by the attending p in by the funeral director, page 2 should be detached for use as	Certification;	3 Suicide 6 Could not be determined 28e. Place of building	of Injury - At home, g, etc. (Specify)	farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
	pital ours a sersi D	Ce	29a. Certifier 1 Certifying Physician: To the	had of my leady lad		4.44-2	4.44-1				
	To the Hospital or Attending Physician: The tay within 24 hours after death. To the Funers! Director: After this certificete hes completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the la 2 Medical Examiner: On the ba and mann	sis of examination a	ge, death and/or inv	estigation, in my opir	, date and place, nion, death occur	and due to the red at the time,	date and place,	nner as sta and due to	ated. the cause(s)
_	To th within To th compl	Me	29b. Signature and title of certifier			29c. License r	number		29d. Date signed	i (Month, L	Day, Year)
			Matilda H. Sz	, MD		DZE	0250		Dece	mber	14,2006
	5		30. Name and address of person who completed cause	of death (Item 23a) (Type, I	Print)	4 -				,
-			MATILDA H. SO	6701 1	V.C	HARLES	ST. B	ALTIM	ore, h	山. 2	21204
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 5 2006	gistial s Signature	No.						21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2310 PM Kung Oldember 10 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year) Aug 17, 1937 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Country) 69 India 231-58-9618 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 11751 Owens Glen Way United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. 3 ☐ Widowed 4 ☐ Divorced Asian-Indian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) US Department of Elementary/Secondary (0-12) College (1-4or 5+) Supervisory Patent Examiner Commerce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jethalal Shah Girjaben Shah 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kamlesh B. Parikh/nephew 10410 Broadfield Ct Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State West Arundel Crematory 12/13/2006 Odenton, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licenses Homas dania 1411 Annapolis Road Odenton, Maryland 21113 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cutherusclevotic Heart Piseuse rars disease or condition resulting in death) Due to (or as a consequence of): Kena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pertension Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral Director

Completed by

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mesical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

the burial-tra attending physician for use as the hirrial be page 2 funeral filled in by

Division or Vital Records, P.O. Box 68760

Attending Physician:

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IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 TI Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Rockuill

06-09434

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Michael Swidowich Certificate of Death 1. For State Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day December 11, 2006 0200 hrs Michael Jerome Swidowich Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Raltimore Harbor Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Davs Hours Director Country) Maryland 212-36-7426 1**X** M 2 01/09/1939 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 'n 10a. State 10b. County 1 Yes 2 XNo 28a-f show Anne Arundel Glen Burnie hours after death with the Maryland Director 10g Citizen of What Country? 10e Street and Number 10f. Zip Code notified at 6382 South Centenniel Lane Apt. B 21061 United States or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? Never Married 2 X No Yes White f Yes, Give Year Specify Widowed 4 X Divorced Yes 2 X No specify: \$ or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 Forns of Health and Mental Hygiene.

ant: If item 27 is marked other than "r **Baltimore, MD 21215-0036** 12 Engineering Stationary Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Robert Swidowich <u>Amanda Delores Rilev</u> 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle V. Welk (Daughter) 6421 Harthorn Avenue, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Bayview Crematory 12/15/2006 Baltimore, Maryland Important: injury or oth Department Other Specify Donation 5 22. Name and Address of Facility Signature of Funeral Service Licensee Hubbard Funeral Home, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Baltimore Mary Physician Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED UNPENDED use as the burial Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav I ive birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? signed by the bedetache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? this certificate has Yes 2 V No 26 Place of Death (Check only one) 25. Was case referred to medical director, Fo the Hospital or Attending Physician: Be Other₄ examiner? Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 ဥ 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No 5 Pending after death Funeral Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City filled in by 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within To the one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 11, 2006 OCME ashe 00 30. Name and address of person who completed cause of death (Item 23a) 6 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD. 31. Date filed (Mon

OCME 2006

State

2006

State of Maryland / Department of Health and Mental Hygiene 2005 1 - State Registrar Certificate of Death Rag. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 3:20 PM December 11 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical Center Battim 701 Merc If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs. 75 1931 West Virginia Oct. Director 236-46-1802 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Baltimore Directo N/A **Maryland** 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21205 or iteme 23a 952 Armisted Way Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Depertment of Heelth and Mentel Hygiene. I hours after to Important: If item 27 is marked other than "naturel", or item any injury or other traumatic event 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Mabe Pansy Hawks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 952 Armisted Way, Baltimore, Maryland 21205 Samuel Sichette, Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 12/15/2006 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) Gardens of Faith 21. Signatue of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213 texam Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COP Physician /Medical Due to (or as a consequence of) **Examiner** Phrumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires thet the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical ettending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed After this certificate has been si funeral director, page 2 should 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

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2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Vecember 11 200C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21202 Place Paul maela Kapack MD 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

06-09406 Brett Smith

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

rett Smith		State of Maryland / Department of History State Certificate of Department of History State			a. No 200	1000
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19)	1	30. Name and address of person who completed dause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111	Penn Street Raltimore	MD 21201		
	tate	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 31. Date filed (Month, Day, Year) 32 egistrar's Signature	, sim ouest, pailimore,	1410 2 1201		
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		1 - For State Registrar	State of Maryla		artment of F		F	Reg. No.	06	4000	53
Physici		Decedent's Name (First, Middle, VIRGINIA B.	Last) ALDWIN SHURE				2. Date of Dea Month Decembe		ეწწ	3. Time of De 1:40A	ath M
/Medic Examin		4a. Facility Name (If not institution, Edenwald			4b. City, Town, or TOWSO			4c. County			
Funeral Director		212-18-3263	3. Sex 1 □ M 2 XX 7. Age (In y.	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		1922	9. Birthp New	lace (State or F	oreign
should be filed within 72 hours after death with the Maryland and Manil Hygiene. I Hygiene I Hygiene I Hygiene I hat well call Ever items 23s or 28s-f show unafte event, I'm Medical Ever item must be rediffed at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim 10e. Street and Number		City, Town or Lo	cation 10f. Zip Code			10g. Citízen of		0d. Inside City I 1 ☐ Yes 2	
th with 23a or ust be	ai Di	800 Southerly Ro			2128	6		USA			
Definition 6.1, Will year of 2.12.13.0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mandal Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other treumatic event, Item Maryloal Evanities interest to collises at once.	by	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes XXXo	Specify:	(Specify Yes or No- arto Rican, etc.)	Specif	<i>y</i> -	etc. ite	
within 72 h ene. than "nati	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Nemaker	ation during most of w d)	vorking	16b. Kind of B	usiness/Ind		
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C, Maly 1 and 2 shou Health and M tem 27 is mar	_	19a. Informant's Name/Relationshi William Henry Sh		nd 800	ng Address (Street Southerly	and Number or Road #	Rural Route Numbe	n, City or Town,	State, Zip land	^{Code)} 21286	
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permit. Page Department (Importent: if eny injury or		21 Signature of Funeral Service Li	eshen Ken	acis	6500 Yor	k Road	itchell-Wied Baltimore	Maryla			
Physician /Medical Examiner pue	Examiner	23a. Part 1. Enter the disease, or simplications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Constitute. The constitution of the constitution of the constitution of the constitution of the constitution of the constitutions of the constitutions. The constitutions of the constitutions of the constitutions of the constitutions of the constitutions of the constitutions of the constitutions of the constitutions of the constitutions of the constitutions of the constitution									
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The law requires that the death certificate are been signed by the attending phys page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowy	1 Live birth 2 F	23c. If yes, outcome of pregnancy 1						e of delivery hth Day Year	
quires that an signed build be deta	by							d tobacco use contribute to the cause of death?			_
vical necolor sicien: The law requir certificate has been si rector, page 2 should t	Completed						24a. Was autop perfo 1 □ Yes	rmed?	death?	psy findings ava mpletion of caus 2 No	ailable se of
VII.	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatie	nt 3 DOA Oth	00 1 20	eath (Check only only only only only only only only		ner (Specifi		
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he Hospi n 24 hou he Funei pietely fiil	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best of my xaminer: On the basis of examand manner stated.	knowledge, deat unation and/or in	h occurred at the tir vestigation, in my c	me, date and pla ppinion, death oc	ce, and due to the c curred at the time,	cause(s) and m date and place,	anner as st and due to	tated. the cause(s)	
Withi Tot com	Σ	29b. Signature and title of certifier	'L		29c. Licens			29d. Date signe			1001
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Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	-	<i>-11.10,</i>	ILLIA	1)130,	CINI	1170	(1)	76)
Regist		DEC 1 5 2	2006 Since	K A	est.						

DHMH 17 Rev 1/2001

ORIGINAL

06-09396 Richard Spicknall

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State of Maryland / Department of Health and Mental Hygiene

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Physicia dical Exami	an/	Decedent's Name (First, Middle,Last) Richard W. Spicknall			2. Date of Death Month December	1	3. Time of Death 2008 hrs		
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Funeral Director			Months Days		_	Forei			
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D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s		panic Origin? (Sp , Mexican, Puerto		White, etc.	rican Indian, 8lack,		
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Richard W. Spicknall			Lynn Go	stomski			
	1	Cheryl Romey / Aunt 10/5 Jo	ohanna	t and Number or F Court F	Pasadena,	er, City or Town, State, Maryland	e, Zip Code) 21122		
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traum		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory 12/12/2006 Baltimon							
Balti permit Departi Import injury		21 Signature of Funeral Service Licensee 22. Name 4001	and Address Ritchi	of Facility Gor. e Highwa	ice Funer ny Baltin	ral Service More, Mary	P.A. Land 21225		
Physician /Medical		236. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.	node of dying,	such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
Examiner		Immediate Cause (Final disease or condition resulting in death) Canadiate List applications ASPNYXIA Due to (or as a consequence of):							
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
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To the Hosp within 24 ho To the Fune completely f	Medical C	29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred and manner stated Certifying Physician: To the best of my knowledge, death occurred and manner stated							
F % F 3	Me	29b. Signature and title of certifier	29c. License			29d Date signed (Mo			
5		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn S	Street, Balt	imore, MD 21	201				
	tate		20						

DHMH 17 Rev 1/2001 OCME 2006

06-09395 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Karen Templeton State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day December 9, 2006 Medical Examiner Karen 1910 hrs Anne Templeton 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Greater Baltimore Medical Center Towson **Baltimore County** 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Days Director Months Hours APR 9, Country) NY 152-88-4117 1985 1 M 2 X F 21 Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. X Yes 2 No N.ISalem Woodstown after death with the Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 55 Grange Court 08098 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Was Decedent Ever in U.S. 14. Race - American Indian, Black must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married White etc. Yes Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify Specify: White traumatic event, the Medical Examiner "natural", ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 in nent of Health and Mental Hygiene If item 27 is marked other than Baltimore, MD 21215-0036 3 Student N/A17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Templeton James Donna Bristow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Templeton/Mother 55 Grange Court Woodstown, NJ 08098 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) or other 1 X Burial 2 Cremation 3 permit Pages
Department of
Important: 1 Joseph's Cemetery 12/15/06 Donation 5 Woodstown, NJ Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Todd Dring Layton Funeral Home 1.000 23a Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** Approximate Interval failure. List only one cause on each line Retween Onset and /Medical Death Streptococcus viridans sersis Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of) b. Diffuse puritonitis Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical X UNPENDED attending physician or use as the burial AMENDED #23a-b,27, perME, g863, 1/11/07 TT To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate has performed' Yes 2 Yes 1 1 25. Was case referred to medica 26. Place of Death (Check only one) Be Inpatient Nursing Home 5 Residence 6 **✓** Yes After 28a. Date of Injury (Month, Day, Year) Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c Injury at Work? Certification: 1 X Natural Pending Yes 2 No within 24 hours after death To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E December 10, 2006 ok 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

31. Date filed (Month, Day, Year)

 BEC

32. Registrar's Signature

			1 - For State Registrar	State of Maryla		artmer rtificat				R	g. No.20	06	40066	
	Physici /Medic		1. Decedent's Name (First, Middle, La Helen D. T	yner						Date of Deat Month	Day 13	Year 06	3. Time of Death	
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e, Mar	s 1 and 2 should if Heelth end Mer Item 27 is marks other treumatic		19a. Informant's Name/Relationship Raymond Tyner	/husband	19b. Maili 1 !	52 C	owhi	de Ci	r Rural F rcl Dat	Route Number, e Balt	imore	MD	21220	
Baltimore,	Page nent o ant: # arry or		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	Removal from State fy)	cemetery, cres	matory or d	other place Ceme	tery	12/	16/06		more	e MD	
Bal	Depertition Depert		21. Signature of Funeral Service Lice	growly.	1	Conne	elly	Fune	ral	Home	of Es		21221 Approximate	
8760,	Physician /Medical Examiner	lical Examiner	23a. Part Enter the disease, of shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	Sequence of): ISCL Aquence of):	nem	4						Intervat Between Onset and Death	
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Vital Records,		Completed		,					_	24a. Was ar autops perform 1 Yes 2	red?	Were auto prior to co death? I Yes	opsy findings available impletion of cause of	
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)	To To To	2	29b. Signature and title of certifier	ONUKO	Su		c. License R€S		00		d. Date signed			
	5		30. Name and address of person who Dr. Ada Ku Onu	1KOgu, 9001	OFrai	Print)	nS	yuar	re:	Drive.	Baltir	no re	-06 MD2123	
	Sta Regista		31. Date filed (Month, Day, Year)	d2. Registrar's Sign	nature	or all s	r	V		- '				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2006 2006 9 45 P M Barbara Ε. Tennien 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3006 Brinkley Road #102 Temple Hills Prince George's 8. Date of Birth (Month, Day, Year) Oct. 16,1933 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Days 1 M 2 F 73 577-42-1146 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3006 Brinkley Road #102 20748 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 HNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify. 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8t h College (1-4or 5+) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Humes Chester Maske 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9314 Cherry Hill Road #808 College Park, MD 20740 Renee Lopez (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec. 13. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XIXCremation 3 ☐ Removal from State Lee Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition radyr disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Be Completed

Medical Certification: To

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed vent of Health and Mental Hygidint: If item 27 is marked other

permit. Pages 1 and 2:9 Department of Health at Important: if item 27 is any injury or other trau

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar for t signed t page 2

Division or Vital Records, P.O. Box 68760,

24 hours after death Funeral Director: filled in by

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify)	Month Day Year				
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?				
Hypert	ension	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
Dejore.	thyroidism	24a. Was an autopsy performed? 1 Yes 2 No 1				
25. Was case referred to e ical examiner?		h (Check only one)				
1 Tes 2 to tho	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence 6 □Other (Specify)				
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	sician: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.					

within 2

31. Date filed (Month, Day, Year)

29b. Signature and title of certific

RAHIMIAN MD 32. Registrar's Signature

arun au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7501 SURKATTI ROAD 205

29c. License number

D0052999

29d. Date signed (Month, Day, Year)

2006

State Registrar

State of Maryland / Department of Health and Mental Hygienes 40068 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 14, 2006 Ruth Emeline von Briesen 6:25am [™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fairhaven Health Care Center Sykesville Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2√☐ F 214-26-8800 1909 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ma 23a or 28a-f ehow 1 ☐ Yes 2 XNo Director MD Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7200 Third Avenue 21784 USA or Itama 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itan any injury or other traumatic event, the Medical Exemper page. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 XWidowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad Personnel Dept. Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John C. Brissenden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John W. von Briesen (Son) 225 W. Lanvale St., Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 12/16/2006 | Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HATCHT FUNERAL HOME & CHAPEL, PA (Bo Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Priysician Conentra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ng physician and as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 Ho
9 Unknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icate has been signer, page 2 should be d à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wasan certificate has autopsy oerform 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifie 307 Westminste Mp 2167 MG 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) 10 Willsu Kus Stone 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

06-09441 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Justin Travers Vanfleet State of Maryland / Department of Health and Mental Hygiene 2006 40069 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day December 11, 2006 Medical Examiner 0741 hrs Justin Travers VanFleet 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 821 N. Marlyn Ave **Baltimore County** 5 Social Security Number If Under 24Hrs 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year B Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Director 218-88-0102 1 X M 08/18/1975 2 Country) Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Yes 2 X No 28a-f show Maryland Baltimore Essex with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 821 North Marlyn Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Yes If Yes, Give Year 3 Widowed 4 Divorced White 1 Yes 2 X No specify: Specify: 'natural', ģ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 the Medical th and Mental Hygiene 27 is marked other than Baltimore, MD 21215-0036 Construction Equipment Operator 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Donna Marie Fleener Department of Health and Mental F Important: If item 27 is marked injury or other traumatic event, Be Stephen VanFleet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen VanFleet (Father) 700 Norris Lane, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 crematory or other place) Removal from State 12/14/2006 Moorefield, West Va. Olivet Cemetery 4 Donation 5 Other Specify 22 Name and Address of Facility Bruzdzinski Funera 1407 Old Eastern Avenue, 21 Signature of Fundred Same Line 150 Funeral Home, P.A. venue, Essex, Maryland 21221 23a. Part I. Englishe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** List only one cause on each line /Medical Death Cocaine intoxication Immedia Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that imitiate a events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED burial -AMENDED physician #23a,27,28a-f 2863, 1/11/07 TT perME. P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery use as the 23b. Was decedent pregnant in the past 12 months? Live birth Ectopic pregnancy Month Fetal death Dav Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, Completed been 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of has performed? certificate раве 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene this No 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural after death Director: / Pending 1 Yes 2 X No in by the Fnd 12/11/2006 FNd 7:05 am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 821 N. Marilyn Ave. 3 6 X Could not be Suicide determined residence Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the Funeral

OCME 2006

117 Rev 172001

Medical

Theodore M. King, Jr., MD 31. Date filed (MDE, Coy Year) State 2806 Registrar

29b. Signature and title of certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 egistrar's Signatur

and manner stated

Name and address of person who completed cause of death (Item/23a)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d Date signed (Month, Day, Year)

December 12, 2006

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 40070

		Registrar Certificate of Death		J. No.	,00 100
Physici		1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death
Medical Exami	ner	James E. Wag staff	November	16, 2006	2238 hrs
and the same of th		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	ath
		Peninsula Regional Medical Center Salisbury		Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9.	Birthplace (State or eign
Director		219-26-4562 1XM 2 F 67 Yrs. Months Days Hours Min.	Apr. 1 29		Country)
		Usual Residence of Decedent	I WILL ON	, 11 - ()	1 100
auk		10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
bid show	Ļ	Md. Dorchester Cambridge			1 Yes 2 No
Maryland 28a-f show d at once.	ç	10e. Street and Number 10f. Zip Code	100	g. Citizen of What C	ountry?
he M or 2 fred	Director	618 Greenwood ave 21613		1)<1	
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once	<u>_</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14 Race - Am	erican Indian, Black,
eath v item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc	
		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	lack
urs af turral	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	ork done	16b. Kind of Busines	s/Industry
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36 thin 72 than than	du	11th horse Trainer	-	Selte	morrised
5-0036 Iled within 72 hours after Hygiene. 4 other than "natural", the Medical Examiner.	Completed	17. Father's Name (First, Middle, Last) 18.Mother's Name		aiden Surname)	11109
21215-0036 zuld be filed within 7 Mental Hygiene. marked other than c event, the Medics	Be (I saigh lurner Roxa	cnna	White	2
21; Ould b	ဥ	19a Informant's Name/Relationship (Type, Prini/ 19b Mailing Address (Street and Number or R		er, City or Town, Sta	ate, Zip Code)
nore, MD 21215 ages I and 2 should be file nt of Health and Mental H II: If item 27 is marked other traumatic event, if	İ	Janet Ahuloo/daughter/6/8 Greenwood Ou	e Apt. 10	1 Campria	land. 21613
e, e, land land Healt Healt item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit Pages I an Department of Hea Important: If ite		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify:	112/11	C ())
를 일을 들다.		4 Donation 5 Other Specify: Donation 5 Other Specify: 22. Name and Address of Facility 2	1 × 100	amoria	ge mu.
Balt permit Depart Impor injury		Uni & Ochac C	الار و	om it i	uneral Home
Physician		26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval
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	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan		23d. Date of deliv	
	iai	past 12 months?	ТСУ	Month	Day Year
cords, P.O. Box 6 aw requires that the death cer has been signed by the attendi 2 should be detached for use	ysi	1 Yes 2 No 9 Unknown 9 Unknown			
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COT law ra has b	鱼		autopsy perform	prior to	o completion of cause of
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by Sic	ဥ	1 Yes 2 No No Inspired 1 Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing		esidence 6 🗸 Oth	ner: Scene
ion of tending Pheath		E (Month, Day, Year)		w injury occurred	struck by vehicle
Division of Vital Records, tal or Attending Physician: The law requir rs after death all Director: After this certificate has been siled in by the funeral director, page 2 should t	aţi	1 Natural 5 Pending FOUND: 1 Yes 2 No No Nov 16, 2006 1801 hrs		onan operator	on don by vernoic
ViS or At firer of Direction by	ij		28f. Location (Str or Town, Sta		Rural Route Number, City
Divisipital or At ours after d	Certification		West of Ocean	Hwy & State Stre	et, Delmar, MD
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendi		29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
o the ithin o the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	the time, date ar	nd place, and due to	the cause(s)
F \$ F 5	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	Month, Day, Year)
		Theody the King Thy wis. O.C.M.E.		November 17,	2006
	- 1	3 Name and address of person who completed cause if death (Item 3a)			
7		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201		
S	tate	31. Date filed (Month, Day Year) 32. Registrar's Signature			
Regis		DEC 1 5 2006 Brown It Aprelle			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Month Year **Physician** 10 ~122006D cemp /Medical 4c. County of Death 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Sal himove NUT If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 1 Year Days 7. Age (fin yrs. last birthdey) 5. Sociel Security Number **Funeral** 1□M 20 F Months Hours 7,1910 214-18-7025 Usuel Residence of Decedent Director filed within 72 hours efter death with the Merylend 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryler Department of Health end Mental Hygiene.
Important: If them 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinor mans be notified at any injury or other traumatic event, the Medical Examinor mans be notified at 1 Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 577 21206 USA (ircle 14. Race - American Indian, 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) House Wif Own Home 11 th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Lucinda Jartin harlie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Circle # A Baltimore 12774 Hazelwood Cowina Daughte 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dukaney Valley 12-16-06 Mem Garden! Timonium 4 ☐ Donation 5 ☐ Other (Speqify) 22. Name and Address of Fecility Chatman-Harris Funeral Home 21. Signature of Funeral Service Ucensee aris 5240 Reisterstown Rd Baltimore Md 21215 23a. P 11. Enter he dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the upon commons within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Tes 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Neturel 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medicai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifig son who completed cause of deeth (Item 23e) (Type, Print) 30. Name and address of pe 31. Date filed (Month, Day, Year) 32. Registrar's Signature 0

DHMH 16 Rev 6/95

State

Registrar

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 6:08 AM **Physician** WHALEN MARION 12 $2\alpha \alpha$ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore City Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 2□ F Jan 29 1941 Director 220-36-2899 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 2 Yes 2 □ No Director MD Baltimor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene, Important: if Item 27 is marked other than "natura!" -- any Injury or other traumatic events. 12110 W. a1230 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔁 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 Yes 2 1 No Specify: þ Specify: 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +h borev 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) un K Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimber sheridan Balto, MD 21230 1216 W. Cross St 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fernation 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State 12-18-04 5 (Specify) 4 Donation Metro (xymotor 22. Name and Address of Facilit 21. Signature of funer previce Licen Midvalley Dr. ILAM 1232 23a. Part Enshock, or Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Physician /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⚠No 24a. Was an autopsy 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury

The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records,

attending physician and for use as the burial-transit signed by the a certificate has birector, page 2 s this After

Medical Certification: To Be

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and tipe of certifier

DEC

To the Hospital or Attending Physician: funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License numbe

Greene St. Baltimore

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

39. Name and address of person of death (Item 23a) (Type, Print)

Shanel 150 31. Date filed (Month, Day, Year)

1 5 2006

6 Could not be determined

22. Registrar's Signature

225.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 7, 2006 Month **Physician** Credalla White December 10:13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore Gilchrist 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 214-40-4769 85 Octob: 11,1921 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1. Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? West 21215 Strathmore Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by Specify: Black 3 Midowed 4 Divorced alth and Mental Hygiene.
27 Is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Healthcare RN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Finney, Sr. Gladys Virginia ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. Biaine White 3204 West Strathmore Ave. Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry December 8: 2006 Hanover, MD 4. Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature Funeral Service Licensee Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pra nuclear Physician Kars disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha performed 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

DEC

1 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

5205

N. Charles St. Bolts. Md 2, 20x

29d. Date signed (Month, Day, Year)

December 13, 2006

			1 - State Ragistrar	State of Marylar			nt of Health te of Death			eg. No.	006	40074
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				1	2. Date of Dear Month	th Day	Year	3. Time of Death
	/Medi		Loretta M. Wood						12	11	2006	9:10P ^M
	Examir	ner	4a. Facility Name (If not institution, give			4b. City	, Town, or Location	of Death			ounty of Death	
			Prince George's F 5. Social Security Number 6. Se		last hirthday)		verly or 1 Year If Under	r 24 Hrs	P. Dato of Pieth	Prin	ice Geor	rge's
	Funeral Director			M 210 F 7.1	Yrs.	Months		Min.	8. Date of Birth (Month, Day, 03-15-1	Year)		lace (State or Foreign
			Usuat Residence of Decedent						33-13-1	935_	Virg	ınıa
	yland		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	a-f-a	ctor	MD Prince Ge	eorge's Ca	pitol I	Heigh	nts					1 ☐ Yes 2🏋 No
	or 28	Director	10e. Street and Number			10f. Z	p Code		1	0g. Citizer	n of What Coun	itry?
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	ral	505 Sulfolk Avenu	ie #404			20743			US	SA	
	r de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Dece f Yes, sp	edent of Hispanic Or ecify Cuban, Mexica	rigin? (Spec an, Puerto R	ify Yes or No- ican, etc.)	14.	Race - Americ Black, White,	
	orl	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give	1	Yes	2XNo Specify	<i>r</i> :		Sp	ecity: Whit	te
2000-0	within 72 hours after ene. then "netural", or Ite		15. Decedent's Ed	Year or Dates:	16a Dagad	lont's Ha	ual Occupation			16h Kind	of Business/Inc	d.com.
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2	be filed within 72 hours after death with the Marylan hal Hyglene. od other then "netural", or Iteme 23a or 28a-f show event, the Macikal Examinat must be notified at	0	17. Father's Name (First, Middle, Last)		12000			ner's Name ((First, Middle, I			
yiand	should be to nd Mental in marked or umatic eve	To B	George Caves				F1c	orence	Jenni	ngs		
	s 1 and 2 should it Health and Menitem 27 is marked the traumatic	Γ.	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Addres	s (Street and Numb	per or Rural	Route Number	City or To	own, State, Zip	Code)
, Ma	and 2 Balth a n 27 le		Terri Moreland/Da		505 S	Sulfo	1k Ave,	#109.	Capito	l Hei	chts. M	20743
ני כ	of Heall of Heall fitem 2 r other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	20b. F	Place of Dispos cemetery, crem	sition (Na natory or	me of other place)	Da	ite	20c. Locat	tion - City or To	wn, State
	Pages ment of ant: If it ury or o		4 □ Donation 5 □ Other (Specify) Wa	shingto			12-18-			and, MD	
	permit. Pages Depertment of I Important: If the eny injury or or once.		21. Signature of Funeral Service Licens	500	22	. Name a	nd Address of Facil	Marsh	a11's 1	Funer	al Home	of MD, In
_	80559		23a. Pany. Enter the disease, or comp	Karshall							land, M	ID 20746
,000	/Medical Examiner bhysicien and sthe brutal-transit	cal Examiner	Sequentiaty list conditions, and the description of the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	illieniga of):							
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	The law re ste has bee page 2 sho	Completed		-					24a. Was a autops perform	y ned?	4b. Were autor prior to con death?	osy findings available inpletion of cause of
AILGI	ifficet or. pa	0	25. Was case referred to medical				ge Di	o of Dooth		No No	1 🗆 Yes	2LI No
	Physician: r this certific ral director.	To B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	t 3 🗆 D	Othor		(Check only on		Other (Specify	
5	ding Phy h. After this funeral c	tlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of tnjury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work? 1 Yes 2	28	Bd. Describe ho			9
DIVISION	after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre fy)	eet, facto	ry, office	28	3f. Location (St City or Town	reet and N n, State)	lumber or Rural	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely illed in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	/sicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred estigatio	d at the time, date and in my opinion, dea	nd place, an ath occurred	nd due to the ca	ause(s) and ate and pla	d manner as sta ace, and due to	ated. the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier				c. License number	5		/	igned (Month, L	
			No. B	norts			D4218	3		12/1	1/06	
			30. Name and address of person who of DR KAREN BROW	4			L DR		CHEVE	RLY	1/06 MD 0	20185
48	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa		- Ba				/		, , , , , , , , , , , , , , , , , , , ,

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Marylar	-			ealth a Death			Reg. No.	006	40075
	Physici	an	Decedent's Name (First, Middle, La								2. Date of Dea Month	ath Day	Yeer	3. Time of Death
	/Media		Evelyn Your								12	11	200	
7	Examir	ner	4a. Fecility Name (If not institution, give						Location of				ounty of Dea	
			Corsica Hills I			last birthday)		entre er 1 Year	Ville If Under		8. Date of Birt		een Ai	
	Funeral Director			I □ M 2 🂢 F	92	Yrs.	Months		Hours	Min.	(Month, Da) Feb. 1	v. Year)		rthplace (State or Foreign ountry)
	ס		Usuet Residence of Decedent										- <u> 1</u> v	
	nylan show		10a. State 10b. County		10c. Cit	ty, Town or Lo		ville						10d. Inside City Limits 1 ☐ Yes 2X No
	8a-1	Director	Alle A	rundel		Davi			= 					
	72 hours after death with the Maryland naturel', or iteme 23a or 28e-f ehow Jisal Exactinat routt be notified at	F	10e. Street and Number 3525 Williamsb	ıra Rd.			10f. Z	ip Code	21035			_	on of What C	ountry?
	eath ve 23	by Funerai	11. Marital Status	12. Was Decede	nt Ever in II	S 13 1	Was Dece				cify Yes or No			erican Indian,
"	fter d	Ë	1 Never Married 2 Married	Armed Force	s?	1			n, Mexicar	n, Puerto I	cify Yes or No Rican, etc.)		Black, Wh	
036	el'.o		3 Widowed 4 □ Divorced	If Yes, Give Year or Date	s:		1 🗆 Yes	2 ⊠ No	Specify:			S	ipecity:	White
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr			16a. Dece	dent's Usi	ual Occupa	ation Ju <i>ring mos</i>	at of working	na	16b. Kind	of Business	s/Industry
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	Hygie Hygie other t		6 Yrs. 17. Father's Name (First, Middle, Last	1		110000			18 Mothe	er's Name	(First, Middle,			
Maryland	d be f	Be C	William Laykeman								e Kappe		arriarrie,	
Z	should nd Men marks umatic	ဠ	19a. Informant's Name/Relationship			19b. Mailir	ng Addres	is (Street a			l Route Numbe		Town, State,	Zip Code)
	alth a 27 is		Mark W. Young	grandson	L	3525	5 Wil	liams	sburg	Rd.	Baltim	ore M	ld. 21	035
J.	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		20b. f	Place of Dispo cemetery, crer	sition (Na	ame of other place	e)	Dec D	f4,	20c. Loca	ation - City o	Town, State
Ë	Page ment ent: if ury o		4 □Donation 5 □Other (Speci			Oak LAv					006	Balt	imore	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or iteme 23a or 28a-f show with injury or other treumatic event, the Medical Examinating the notified at ADGE.		21. Signature of Funered Service Lice	nseré		Č	Name a	Ty Fi	s of Facility	1 Hor	ne Of D	undal	.k	
			23a. Part1. Enter the disease, or con	plications that caus	sed the deat						Rd. 212 r respiratory ar			Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	43										Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Sepsi	as a consec	uence of):							-	Iweek
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1/2 .	and I-trans	Examiner	that initiated events resulting in death) Last	c. Faul	as a consec	ti e	hru	JC						6month
8760,	Physicien: The law requires that the death certificate be executed to this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burist-transit.	ical	l	0.0000	200000	(a 0.100 01).								
687	ficate phys s the	dic	^ 2	d										
Box (certif nding use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23	d. Date of de	alivery
	that the death certifica ed by the attending ph detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth	t at time of c		JEctopic ¡ ∃ Other (s	pecify)					Month	Day Year
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Records,	w requir been si should t	Completed	Kheur	nativid	7120	mutu	3				101	/es 2 🗆	No 3 P	robably 4 Onknown
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<u> </u>	: The	ပ္ပ										2 No	death? 1 ☐ Ye	s 2 No
ŽĮ.	ilcien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	er /		(Check only o			
Division of Vital	Phys ral dir	- T	1 ☐ Yes 2 ☐ Vo 27. Manner of Death	1 Inp:		ER/Outpatier		OA	Nu		ne 5 🗆 Resid			ecify)
on	ding th. Afte fune	ţ	1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,	Day Year)	Injury	м	28c. Injury Work 1 🗆 `	? Yes 2□					
İSİ	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not t	28e. Place of	Injury - At h	ome, farm, str	reet, facto	ry, office		2			Number or F	lura I Route Number,
á	al or safe	Certification:	4 Homicide	building,	etc. (Specia	(y)					City or Tow	vn, State)		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medicat Exa	hysician: To the be miner: On the basis and manner	s of examina	owledge, deatl	h occurre vestigatio	d at the tim n, in my op	e, date an pinion, dea	nd place, a oth occurre	and due to the and at the time,	cause(s) a date and p	nd manner a lace, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner	stateu.		29	c. License	number		and the same of th	29d. Date	signed (Mon	th, Day, Year)
	⊢ s ⊢ ŏ		> REDUCY				D	006	1688			12	13/06	
	_		30. Name and address of person who	completed cause of	of death (Iter	п 23а) (Туре							100	
	3			uni.	2108	DDO	nah	ים כו	we	Ch	ection.	MD	2161	9
	Sta	ate	31 Date filed (Month_Day Year)	006 32 Aeg	istrar's Signa	ature de	asti 1)						
	Regist	rar	Pro T 9 5	000	الر مايان	a fall								

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			1 - For AMEND#10E Per FH State RegistrarAACO HEALIH DE			nt of Health te of Deat	th	Re	g. No.)6	40077
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	ulton				2. Date of Death	Day (X	Yeer 0.	3. Time of Death 12:50P M
	Examin		4a. Facility Name (If not institution, give		1	, Town, or Location			4c. County		
			Anne Arundel Med			napolis			Anne		undel
	Funeral Director		5. Social Security Number 6. Sep 315-24-9753 15 Usual Residence of Decedent	7. Age (In yrs. las	Yrs. If Under		rs Min.	B. Date of Birth (Month, Day,	Year) 1913	9. Birth Cou Mal	place (State or Foreign intry) Yland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medicul Exatt far minate rollified at ance.	ctor	10a. State 10b. County Anne Au	und Ri	Town or Location						10d. Inside City Limits 1 ☐ Yes 2 █️No
	with th	Director	10e. Street and Number 3201 Bree	kenridge Way	10f. Zi	ip Code		10	g. Citizen of	What Cou	intry?
	s 23s	Funerai	SOUL DERG	12. Was Decedent Ever in U.S.	U77 2	21190	Origina /Sana	tu Van an Na	11 BY	Amor	ican Indian.
	itam itam	un-	11. Marital Status 1 X Never Married 2 Married	Armed Forces? 1 Yes 2 No	If Yes, spe	edent of Hispanic ecify Cuban, Mexi	ican, Puerto R	ican, etc.)		ck, White	
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2XNo Spec	cify:		Specif	יי B1a	ack
21215-0036	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		16a. Decedent's Usu	ual Occupation ork done during n	nost of working	, 1	6b. Kind of B	lusiness/l	ndustry
7	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	nost or working				
2	filed w Hygier other th	Co	7th	0	Domes						Family
and	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental Count, The Mental County, Th	Be	17. Father's Name (First, Middle, Last) Richard Aulton					First, Middle, M e Hall		πe)	
3	should and Men a marke umatic	2			401 41 11						
Maryland	d2 st th and 7 is n traun		19a. Informant's Name/Relationship (Ty Phyllis C. Murra		19b. Mailing Addres						
	1 and Health am 27 thar tr		20a. Method of Disposition		pe of Wieposition (Ne netery, crematory or		Luge W		Oc. Location		
0	Pages nant of I int: if its		N Burial 2 ☐ Cremation 3 ☐ P	emoval from State Chu	hbtery, crematory ar rch Ceme	otherplace) terv	11-28		aterb		
Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens			ක්දිල්දිණි o <u>K</u> s	<u>i</u>				, 110.
Ba	permit. Departn imports any inju		170-0 1 A	1000 MON 483		est St.					1 1
	F-12		23a. Part1. Enter the disease, or compl	cations that caused the death.				A-		211	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final		0 . (1 P : 1 P					Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):	12 6 476	-				
н	Examiner			DEPRE							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen							
	nd trans	Examiner	that initiated events	.							
, 0,	sician and burial-translt	EX	resulting in death) Last	Due to (or as a conseque	nce of):						
8760,	cate be ex physician the buria	Physician/Medical		d							
9	leath certifica attending ph for use as th	Mec	IF FEMALE:	2- 16							
Вох	attend for us	ian	in the past 12 months?	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal d	leath 3 Ectopic p					ate of deliventh	very Day Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	th 5 ☐ Other (s	specify)	-				
Δ.	res that the death cer igned by the attendin be detached for use		Part II. Other significant conditions con	ntributing to death but not resulti	ing in the underlying	cause given in Pa	art I.	23e. Did toba	acco use con	tribute to	the cause of death?
Vital Records,	The law requires that the death certificate be executed to has been signed by the attending physician and to be 2 should be detached for use as the burial-transit	d by						1 🗆 Yes	s 2 🗆 No	3 🗆 Pro	bably 4 Honknown
COL	w requir been si should	iete						24a. Was an	24h	Were aut	opsy findings available
Re	The lav	Completed						autopsy perform	ed?	prior to co death?	ompletion of cause of
ta	<i>to</i> □	C	25. Was case referred to medical			ne Di	lace of Dooth	1 □ Yes 2 Check only one		1 🗆 Yes	2 ∐ No
>	Physiclan: this certific al director,	To B	eyaminer?	fospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient 3 D	Other		e 5 Resider		ner (Snec	ifv)
o t			27. Manner of Death		8b. Time of	28c. Injury at Work?		3d. Describe hov			
jo	Attending For death. Sector: After by the funer.	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Worth, Day 1 ear)	Injury M	1 ☐ Yes 2	2 🗆 No				
Division	or Attendate death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ry, office	28	3f. Location (Str. City or Town,		ber or Ru	ral Route Number,
	ital or A rs after al Dira ed in by	Cer									
	To the Hospital or Attent within 24 hours after death To the Funaral Diractor: completely filled in by the	edical	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination and manner stated.	ledge, death occurred on and/or investigation	d at the time, date n, in my opinion,	and place, ar death occurred	nd due to the car d at the time, da	use(s) and m te and place,	anner as and due	stated. to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		29	9c. License numb	er	29	d. Date signe	ed (Month	, Day, Year)
			- halle	~~ ph	1	03671	6100	9/30/0X	11/2:	1/0	6
	4		30. Name and address of person who co		23a) (Type, Print)	DUC!	- i ext		-		
			3448 40114 A	100 Ar	man	mo	2140	1.11	Mich	all	Riebmar
	Sta Registr		31. Date filed (Month, Pay Year) 9 2	32. Progistrar's Signatur	re						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #18 per FDir State of Maryland / Department of Health and Mental Hygiene AACO.Health 11/29/06 lo 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 23 2006 Robert William November Aubuchon 3:10 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1114 River Crescent Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec 11 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months XXM 2 F 89 487-18-4544 Director Missouri Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Extiminer must be notified at Director 1 ☐ Yes 2 No MD) Anne Arundel Annapolis 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 1114 River Crescent 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1942–68 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: ģ Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other throany Injury or other trailmastic. Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be _ETHEL Shults George James Aubuchon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Aubuchon (Son) 1318 Vineyard Haven, State College, PA 16803 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hillcrest Cemetery 11-29-2006 Annapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 78 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY Jyen ARTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown p signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical **completely** (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 10036371 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) : 3169 RAYMOND E. BANFER BRAVERTON ST EDUCEWATER, MO MO Registrar's Signature

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Registrar

31. Date filed (Month, Day, Year)

NOV

2 9 2006

State of Maryland / Department of Health and Mental Hygien [] [] [

1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 30 VIRGINIA P. ANDERSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Center Salisbury Regional Medical If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAR 27, 1922 Birthplace (State or Foreign Country)

VA 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 K Months Director 218-34-7599 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Examiner toust be notified at Yes 2 □ No Directo WICOMICO SALISBURY MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21801 USA 1109 SOUTH SCHUMAKER DR. itama 23a Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 Yes 2X No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) REGISTERED NURSE HEALTH permit. Pages 1 and 2 should be filed to Depertment of Health and Mental Hygie Important: If item 27 is marked other t. any injury or other traumatic event, Impone. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY ELIZABETH PAYNE VINCENT NELSON PAYNE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 402 WEST GLENVIEW DR., SALISBURY NC 28147 JOHN MICHAEL ANDERSON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/5/2006 HURLOCK, MARYLAND MD VETERANS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause [Final] Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive heart **Physician** /Medical Due to (or(as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Renal signed by the ettending physicien and defeathed for use as the burial-transit or Attanding Physician; The law requires that the death certificate be executed Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown certificete has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funeral Dira t 🖸 Cartifying Physician: To the best of my knowledge, death becurred at the time, date and place, and due to the daube(s) and marker as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ë 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063991 106 128, Reu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VARADARA South Division Street Suik B Salishumm DZ18UY ANUPAMA MD 1415 31. Date filed (Month, Day, Year)
DEC - 1 2 32. Registrar's Signature State 1 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 29, 2006 Sara Lindsay **Bellison** November 10:15A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** 1 ☐ M 2 ☐ ¥F 215-17-2860 19 2, Director Oct. 1987 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State item 27 ie marked other then "naturel", or items 23a or 28a-f ehov other treumatic event, Ita Mudical Examinar must be notified at 1 ☐ Yes 2 No Maryland | Frederick Frederick Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 3802 Sugarloaf Parkway 21704 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 and 2 should be filed within 72 hours after or Health and Mental Hygiene. Im 27 Ie marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary School School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Concetta ၉ Garv R. Bellison Luparello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Depertment of Health as Important: If Item 27 le eny Injury or other treu QDCE. 7114 Collinsworth Place, Frederick, Maryland Gary R. Bellison - Father 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other place) | Commeter, Crematory or other p 21. Signatu e of Funeral Service Licensee 22 Name and Address of Faculty Molesworth—williams P.A., Funeral Home overt " 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE PESPIRATORY FAILIPE Physician /Medical Due to (or as a consequence of) LUNG-METASTARES **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner MELANOMA the attending physicien and hed for use as the burial-transit METATIC certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 △No Year Month Day 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 99 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours eftar death. To the Funerel Director: After Natural 2 Accident 5 Pending 1 🗌 Yes 2 □No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier, D31761 December 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V Brian M. O'Connor M.D. 501 West 7th Street, Frederick, Maryland

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Hattie November 28, 2006 4:11 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🔀 F 89 Yrs. 578-28-0158 North Carolina Usual Residence of Decedent 10d. Inside City Limits 1XYes 2 No 10g. Citizen of What Country? HSA 14. Race - American Indian. Black, White, etc. Specify: Black 16b. Kind of Business/Industry Private Residential 18. Mother's Name (First, Middle, Maiden Surname) Wilder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.G. Area Agency on Aging 6420 Allentown Road, Camp Springs, MD 20748 20c. Location - City or Town, State 12/01/06 Riverdale, MD 22. Name and Address of Facility
Montgomery-Cheatham Funeral Service P.O. Box 388 Upper Marlboro, MD 20773 Approximate Interval Between Onset and Death Left lower lobe Pneumonia with parapneumonic 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🔼 No 1 TYes

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Reg. No.

29d. Date signed (Month, Day, Year) 29c. License number

NOV 2016 D0055120

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328 Southern Avenue S.E. Suite 310 Washington, D.C. 20032 Richard Palmer, M.D. 31. Date filed (Month, Day, Year)

32. Registrar's Signature NOV 3 0 2006

mo

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and

Physician

/Medical

Examiner

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** 5:40 P M Donald Matthew Baker 23, November 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, June 7, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months 1 M 2 □ F Days 386-12-8205 Yrs Director 81 1925 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 28a-f show at notifled 1 ☐ Yes 2 X No Director Silver Spring Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 8 Items 23a must 3142 Gracefield Road, #205 Funeral 20904 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 √Yes 2 No If Yes, Give ō altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify WWII ò Spec/White 3 ☐ Widowed 4 ☐ Divorced 'natural", Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) the Mr Elementary/Secondary (0-12) U.S. House of College (1-4or 5+) Representatives <u>Attorney</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Health and Menta em 27 is marked John Charles Baker ဥ Teresa Binns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Baker/ wife Item 27 i 3142 Gracefield Road, #205, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of IImportant: If Ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State December 2, 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 2006 Germantown, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Sepsis
Due to (or as a consequence of): Days resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physician at the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.0. 1 ☐ Yes 2 ☐ No the 9□Unknown 9 ☐ Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Normal Pressure Hydrocephalus 1 Tyes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No has autopsy perform certificate ha **X**□ No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 1 🔽 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation (Month, Day Year) ★▼ Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the

Registrar

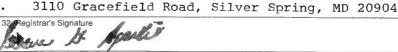
State

31. Date filed (Month, Day, Year) NOV 3 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Eugenio Machado, M.D.



4+1

29c. License number

D24035

29d. Date signed (Month, Day, Year)

November 27, 2006

		000
State of Maryla	nd / Department of Health a	nd Mental Hygiere U U

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:25 P M NOVEMBER BURGE 28 2006 JAMES L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye SEPT 10 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ₩ M 2 🗆 F Yrs. NORTH CAROLINA Director 72 1934 238-48-5442 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or itema 23a or 28a-f show Examiner must be notified at PRINCE GEORGE'S LANHAM MD Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9619 WOODBERRY STREET 20706 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes, S □ No ARMY If Yes, Give 6/53-11-55 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. e filed within 72 hours after de It Hygiene.
other than "naturel", or Item vent, the Nadical Exert than Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CONTRACT SPECALIST FEDERAL GOVERNMENT 2 yrs nt of Health and Mental Hygis, if Item 27 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARTHA K. KORNEGAY WILLIAM BURGE SR. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9619 WOODBERRY STREET LANHAM, MARYLAND 20706 MARGARET L. BURGE/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o once. 1 Burial 2 Cremation 3 Removal from State MARYLAND VETERANS 12/8/2006 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final METASTATIC PANCREATIC CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last physicien ar Due to (or as a consequence of) Box 68760. Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. the þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 XUnknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√□ No page 2 hes certificate 2€ No Division of Vital 1 Tes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ۵ 1 ☐ Yes 2 🛣 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 23s Cartilian Medical To Gardifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cases(e) and marrier as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mahner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63390 NOVEMBER 29, 2006 NU1884 cause of death (Item 23a) (Type, Print) 30. Name ddress of person was completed ETONDE MAFANY MUSONGE-TARKANG M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910 31. Date filed (Month, Day, Yea NOV 3 0 2006 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cert	ificate o	f Deat	th .		, ,	Reg. No.		,
Physicia	an/	Decedent's Name (First, Middle)							Date of De Month	ooth	ar	3 Time of Death
dical Exami	ner	Matthe 4a. Facility Name (if not institution		BUTTS		4h City	Town est	ocation of E	Decemb			1045 hrs
		Interstate 68 east, mil	_			Hand		ocation of L	Jean T	Washing		
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. las	st birthday)		ler 1 Year	If Under 2		Birth (MM/DD/YYYY		
Director		234-33-6325	1 X M 2 F		23 Yrs	Month s.	ns Days	Hours	June	28,1983	Foreigi Cou	n untry)Maryland
ź.		Usual Residence of Decedent 10a. State 10b. County		10c City T	own or Locat	tion						10d Inside City Limits
_ 0% al		West	1 1	•								1 Yes 2 X No
nyland a-f sh t once	ţ	Virginia Ber 10e. Street and Number	keley	Fal	ling W	later				10g. Citizen of Wi	nat Coun	to the state of th
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23n or 28n-f show any matic event, the Medical Examiner must be notified at once.	Director	51 Mobile Cou	rt					419		_	S.A.	,
r death with or items 2	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Decedent Armed Forces?						(Specify Yes or I uerto Rican, etc.)		- Americ e, etc.	can Indian, 8lack,
ifter de		3 Widowed 4 Div	orced If Yes, Give Year or Dates.	X No	1	Yes 2	X No	specify:		Specify:	whi	te
ours a	d by	15 Decedent's Education (Spe-		pleted)				n (Give kind	d of work done	16b. Kind of Bu	siness/Ir	ndustry
nore, MD 21215-0036 ggs 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene 1: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12) 0-12	College (1-4 or 5	5+)	_		1 han		s retired/	food di	stri	bution
5-0036 iled within 7 Hygiene I other than the Medica	힝	17. Father's Name (First, Middle,	Last)		-				lame (First, Middle	, Maiden Surname)	
215 be fille antal H irked	å	Pa		S					Joyce			4
D 21 should be and Mer is mar	욘	19a Informant's Name/Relations								umber, City or Tow		
- p # = #		Betty Butts -	WILE	20b. Pl	ace of Dispos				Date Date	aters, We		virginia _{Town, State} 25419
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medic		1 X 8urial 2 Cremation		ate cre	ematory or ot mony C	ther place)	D	ecember	5		
		4 Donation 5 Other Sp 21. Signature of Funeral Service		mai	_		Address o		2006 Minnic	h Funeral		ters, WV
Balti permit Departii Import injury		Fred Lit	Lestal		41.	5 Eas	st Wi	lson :				aryland ₂₁₇₄
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		the death. [Do not enter t	the mode	of dying, si	uch as card	ac or respiratory a	rrest, shock, or he	art	Approximate Interval 8etween Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a conse							•		Death
		Sequentially list conditions,	b	squerice or).								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):								
ted J ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of).								
frcate be executed g physician and sthe burial - transit	edical	UNPENDED	AMENDED								-	
8760, ifficate be ng physic as the bur	Σ	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcom				2	Totonio na		23d. Date of		
	iciar	past 12 months?	4 Pregnant at		th	etal death ther (Spe		_Ectopic pri	egnancy	Month	D.	ay Year
Box ne death c the atten ned for us	Physicial		9 Unknown									
ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	ğ	Part II. Other significant condit	ions contributing to death	i but not res	sulting in the i	underlying	g cause giv	en in Part I.				he cause of death? ably 4 Unknown
'ds, require seen si ould b	eted							-	24a Wa			opsy findings available
of Vital Records, g Physician: The law requir of the continue has been s meral director, page 2 should t	ompleted								per	formed?	leath?	ompletion of cause of
II R	ပ	25. Was case referred to medica					26 Place o	f Death (Ch	neck only one)	2 NO 1	✓ Yes	2 No
Vital I hysician:	Ö	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient	t 3 🔲 🗆	OOA	ther ₄ N	ursing Home 5	Residence 6	Other.	Scene
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	ion:	27. Manner of Death 1 Natural 5 Pend	28a Date of Inju (Month, Day, You ding Dec 1, 2006)	ry 2 ear)	28b. Time of I 1 045 hrs	Injury :	28c. Injury	at Work? s 2 ✔ No	Driver of	e how injury occurr car collided	ed with	trailer
Division tal or Attendii rs after death al Director: Aled in by the fu	ertification		stigation 28e. Place of Inj	ury - At hon	ne, farm, stre	et, factory	, office bui	lding, etc.			er or Rur	al Route Number, City
Div pital or ours afte reral Dir filled in	Certi	4 Homicide deter	rmined (Specify) Inte	erstate/Ex	xpress				or Town I 68 East @	State) 79 Mile Marker,	Hanco	ck, MD
Di To the Hospital- within 24 hours a To the Funeral I completely filled	Medical ((Oncon only	hysician: To the best of my miner:On the basis of exar	_								
To wit	Mec	29b Signature and title of certifie	and manner stated er			290	c. License	number		29d Date sign	ed (Mon	th, Day. Year)
		Mounte 1	me Male				O.C.M	.E.		December	2, 200	6
		30. Name and address of person	·	,	,	-			15 0/5-			-
14-7		Margarita Korell MD. 31 Date filed (Month, Day Year)	Assistant Medical			enn Str	reet, Bal	timore, N	/ID 21201			
St	56		32. Registrar	rs Signature	9	JE .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 40085 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Ам Charlotte Mae BROWN Nov. 30 2006 3:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Director 86 Maryland Oct. 13 1920 214-14-6064 filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 21740 11316 Manse Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. White Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Harry E. Thomas Fannie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4768 Paynes Ford Road, Kearneysville, WV 25430 Susan B. Mellott - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beaver Creek Cemetery 12/4/06 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acuite veeks /Medical Due to (or as a consequence of): Examiner CONONAM Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.0. 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has performed? Yes 2 No page 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗂 No 1 Inpatient 2 ER/Outpatient 3 DOA cia ၉ After this 28a. Date of Injury (Month, Day Year) ne Hospital or Attending Pt n 24 hours after death. ne Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical within 2 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6701 32. Registrar's Signature

un)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

N. Chniles St. Balto, Md Z. 20%

November 30, 2006

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per verb 8862 12-14-06 vt. State of Maryland / Department of Health and Mental Hygiene

1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:45 AM December 2006 Velma Mellamae Bowman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Months Days Hours 194-56-7176 Director Yrs PA 44 October 12, 1962 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Directo MD Allegany <u>Little</u> Orleans 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 permit. Pages 1 end 2 should be filed within 72 hours after death v Department of Health and Mental Hygiane. Important: if them 27 is marked other then "nature" eny injury or other traumatic events. 11400 Stone Mountain Road 21766 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1☐ Yes 21X No þ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Milton Bailey <u>Joyce Richards</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>April Bohrer/Daughter</u> 186 Hunters Lane Warfordsburg, PA 17267 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Antioch Cemetery 12/11/06 Bir Cove Tannery, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). ettending physician end for use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 1 Yes 2 No After this certification, I Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Yes 25€No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No ours efter death, neral Director: A filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1. Certifying Physician: To the best of my knowledge ideath occurred at the time, date and place, and Jue to the dateso(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 76 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md 26 Opa len 31. Date filed (Month, Day, Year) DEC 1 4 32 egistrar's Signature State 14 Registrar 2006

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Physician /Medical 4a. Facility Name (If not institution, give street and number) Examiner

Chester River Manor

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760,

	5. Social Security N 235-30-		6. Sex	x] M 2(3)(F	7. Age (In	yrs. last bi	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 02/15/	th Year	9. B	irthplace (State or Foreign
					10	, <u> </u>	115.				l	02/13/	190	5	PA
	Usual Residence of 10a. State	10b. County	,		100	c. City, Tov	wn or Lo	cation							10d. Inside City Limits
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To Be Completed by Funeral Director	10e. Street and Nur 200 Mor		oad					10f. Zip	Code 520				-	itizen of What (SA	Country?
ner	11. Marital Status			12. Was Dec Armed F	edent Ever	in U.S.	13.	Was Dece	dent of H	lispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - An Black, Wh	nerican Indian,
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O	Emile La	adrier	e							Luc	ia G	regoire			
-	19a. Informant's Na	ame/Relation:	ship (Ty	rpe, Print)		19	b. Mailir	ng Address	(Street	and Numb	er or Rura	al Route Numb	er, City	or Town, State	Zip Code)
	Margare	t Fail	ing/	/ Daugl	nter		108	3rd	Stre	et, W	lyomi	ng, DE	199	34	
	20a. Method of Disp	position			2	Ob. Place	of Dispo	sition (Nai	ne of			Date	20c. l	ocation - City o	or Town, State
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	23a. Part1. Enter to shock, or hea	he disease, o	r compl	ic tions that	caused the	death. Do	not ent	er the mod	de of dyin	ng, such as	s cardiac	or respiratory a	rrest,		Approximate Interval Between
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y E	Part II. Other signif	ficant conditi	ions co	ntributing to	death but no	t resulting				en in Part	I.	23e. Did	obacco	use contribute	to the cause of death?
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tific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deterr	not be mined	28e. Plac	e of Injury - ling, etc. (S	At home, f	arm, str	eet, factor	y, office			28f. Location (City or To	Street a	and Number or i	Rural Route Number,
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Medical Certification:	29a. Certifier (Check only one)	1 Certifyi 2 Medica	ng Phy I Exami	ner: On the I	e best of mo pasis of exa nner stated.	y knowledg imination a	ge, death nd/or in	h occurred vestigation	at the tire, in my o	ne, date a pinion, de	nd place, ath occurr	and due to the ed at the time,	cause(: date ar	s) and manner and place, and di	as stated. ue to the cause(s)
Me	29b. Signature and	title of certific	er					29	c. Licens	e number	-		29d. D	ate signed (Moi	nth, Day, Year)
	111	1/ill	m	Mi).				D.	213	13		/	1/24/0	6
	30. Name and addr	ress of person				(Item 23a)			A	we	, a	læster	ton	m n	10 2620
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DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per verb e862 12-14-06 vt. State of Maryland / Department of Health and Mental Hygiere 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Ам Evelyn Joyce 12 Bates 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9406 Lakeview Drive Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Hours Director Yrs 217-26-3474 Maryland 4-25-1929 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23a or 28a-f shov traumatic event, the Mudical Experiment the notified at Director 1 ☐ Yes 2X No MDWorcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with 9406 Lakeview Drive 21811 USA by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) t Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare permit. Pages 1 and 2 should be filed.
Department of Health and Mentai Hygi Important: if Item 27 is marked other any njury or other traum-11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Welford D. Shelhoss 2 <u>Princess E. Watkins</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith M. Laser - daughter 20809 Keeney Mill Road, Freeland, MD 21053 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place)
Dulaney Valley 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12-8-2006 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens Timonium, Maryland 22. Name and Address of Facility J. J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licensee W- Murane Mule 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pulmonaris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner to (or as a consequence of): use as the burial-transit 4 W Mets or Attending Physician: The law requires thet the death certificate be executed Mulal that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknow Part II Other significant conditions antinbuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ide 2**K** No 1 Yes 1 Yes 2 No director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. scribe how injury occurred After Natural Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the within 24 hours after deal To the Funerel Directors 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospitel Certifying Ptylsician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Pri

State Registrar

31. Date filed (Month, Day, Year)

			State of Maryland / Depar	tment of Health and Me		
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	/Medic Examin			4b. City, Town, or Location of Death		R 30,2006 8:45A ^M 4c. County of Death
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
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Š.	es th igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the under			to use contribute to the cause of death?
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ပ္	e law nasb e 2 sh	Completed	OSTEOMYELITIS, ANEMIA		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	slcian: The law certificate has t irector, page 2 s	S			performed? 1□ Yes 2☑	
VITal	lcian certifi ector	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one)	
0	Phys this al dir	P	1 Inpatient 2 ER/Outpatient			6 □Other (Specify)
	ding I. After funer	ion	1 ■ Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 Yes 2 No	d. Describe how in	jury occurred
VISION	death ctor: y the	icat	3 Suicide 6 Could not be 280 Bloom of injury. At home form street		f Location (Street	and Number or Rural Route Number,
\leq	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	City or Town, Sta	ate)
	spita nours neral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, an	nd due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inversand manner stated.	stigation, in my opinion, death occurred	d at the time, date a	and place, and due to the cause(s)
	To t To t	Z	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			Amelon Mo	021936		12/3/06
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri A. DONELSON, ND 65C 776MAS	int)	FREDE	RICK, MD 21702
	Sta	te	31. Date filed (Month, Day, Year) 32. Refistrar's Signature	- W.		-, 5 -, 7
	Registr		31. Date filed (Month, Day, Year) OFC 0 4 2006 32. Refistrar's Signature	inelic)		

State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year North **Physician** 2:07 DANIEL CAMPBELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE THE JUHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. **™** M 2□ F Hours 69 Yrs. Maryland Director May 19 1937 236-56-2926 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28e-1 show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or Items 23a or 28e-1 ehov ury or other treumatic event, the Madical Expiriting must be notified at Maryland Anne Arundel 1 ☐ Yes 2 No Gambrills 10g. Citizen of What Country? 10f. Zip Code 1041 Christmas Lane 21054 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 【XNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Military 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Intelligence Officer United States Army 12th 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sidney Carey Clinton Campbell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilbert Turner(Friend) 6887 Edge Creek Rd. Royal Oak, Md. 21662 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Arlington National 1-18-07 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ਅਜਾ ਜਦਦਾ ਦਾ ਦਿਆਂ Sons Mortuary, P.A. Janus S. Reese Moo 483 821 West St. Annapulis,

23a. Part I. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapulis, Md. 21401 Immediate Cause (Final disease or condition resulting in death) CAJCER -47 E 2 MONTHY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year ō Day 4□Pregnant at time of death 5 Other (specify) o 9 Unknown ģ ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Yes 2 No 3 Probably 4 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? Yes 2 No certificate 1 ☐ Yes After this certification 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Lapatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Satural 2 Accident 5 Pending To the most after death.
Within 24 hours after death.
To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No М investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier Decembring Physician: To the best of my knowledge death occurred at the time, date and plane and due to the name(s) and manner as stated Medica Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MEDICAL DOCTOR HOVEMBER 25, 2006 RES- 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1

Registrar DHMH 17 Rev 1/2001

State

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2. Registrar's Signature

GIA LAHORY THE 31. Date filed (Month, Day, Year)
NOV 2 9 2006

			1 - State of Maryland Registrar	-	artment of Health and rtificate of Death		ende UUb i. No.	40092
	Physici	an	Decedent's Name (First, Middle, Last)			Date of Death Month	Day Year	3. Time of Death
	/Medic	al	WILLIAM H. COLEMAN 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	NOVEMBER	24, 2006 4c. County of Dea	
VO.	Examin	er	1519 GOLDSBORO ROAD		INGLESIDE		QUEEN A	
	Funeral Director		5. Social Security Number 214-42-9896 6. Sex 1 № M 2 ☐ F 64	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		(ear) 9. Bir (42	thplace (State or Foreign buntry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation			10d. Inside City Limits
	Mary a-f sh	tor	MD QUEEN ANNE'S ING	LESID	Ε			1 ☐ Yes 2X No
	or 28	Direc	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Co	ountry?
	eath w	Funeral Director	1519 GOLDSBORO ROAD 11. Marital Status 12. Was Decedent Ever in U.S.	13	21644	Enecify Yes or No-	USA 14. Race - Ame	ancan Indian
5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. I al Hygiene. d other than "natural", or Itams 23a or 28a-f show event, I're Medical Examinating to notified at	by	1 Never Married 2 Marned 1 Never Married 2 Natroed 1 Never Married 2 Natroed 1 Never Married 2 Natroed 1 Never Married 2 Natroed 1 Never Natro		Was Decedent of Hispanic Origin? (\$ f Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, Whit	
<u>2</u> -C	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16	b. Kind of Business	/Industry
212	filed withir Hygiene. Ither than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		TAINCE MECHANIC		CHEMICA	L
		Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		-
Maryland	d 2 should be th and Mental t7 is marked of traumatic ev	To	CHARLES A. COLEMAN 19a. Informant's Name/Relationship (Type, Print)	10h Mailie		LE SARAH I		T- 0-1-)
-	12 7 ts		BETTY ANN COLEMAN/WIFE		ng Address (Street and Number or R GOLDSBORO ROAD,		-	
altimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		Cen	netery, crer	sition (Name of natory or other place) ILLE CEMETERY 11/		c. Location - City or	
Balt	permit. Departr Importa		21. Signature of Funeral Service Licensee Auto A. Halfalain	TT	Name and Address of Facility LLLOWS, HELFENBEI SO SPEER ROAD, CH	N AND NEWI	NAM FUNERA MD 21620	AL HOME, PA
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	inco	2~			3 months
*	Examiner		Due to (or as a conseque	nce of):				
A	p ti	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):				*
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Q		Med	IF FEMALE:					
O. Box	at the death certific. by the attending plached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
S.	requires that leen signed b hould be deta	by PI	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ecords,	w require been signal	ted	COPD			1 🖸 Yes	2 □ No 3 □ Pr	robebly 4 Unknown
ľ	The law ate has b page 2 si	Completed				24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
VII	Physicien: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	VOutpatien	Othor	ath <i>Check</i> only nellome 5 lesidence	e 6 MOther (See	0/6/1
ם ח	ding Phy h. After thi funeral o			8b. Time of Injury		28d. Describe how		Cny/
<u> S</u>	or Attending Ifter death. Director: After in by the funer	catle	2 Accident investigation		M 1 Tes 2 No	00/ 1 /0		
DIVISION	al or Al	Certification:	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, tarm, str	eet, factory, office	28f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge (Check only one) Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, date and place restigation, in my opinion, death occurred	e, and due to the caus urred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
		2	29b. Signature and title of confifier	MD	29c. License number D 5 88 3 4	29d	Date signed (Mont	h, Day, Year)
	12 in		30. Name and address of person who completed cause of death (Item 2	116	MAIN ST. GF	TUENA 1	ND 21	635
The Street	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 2 7 2006 32. Registrar's Signatur	s,	Sports			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 4,50 AM 200 ber /Medical 4a. Fecility Name (If not institution, give street and nu 520 S. Main St. DR County of Death 4b. Gity, Town, or Location of Death Examiner last birthday) 9. Birthplace **Funeral** 1□M 2XF Days Min Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. Stale 10b. County "natural", or iteme 23a or 28e-1 show injury or other traumatic event, the Medical Examiner round be notified at 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code S 520 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing_Address (Street and Number or 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Approximate Interval Between Onset and Death . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** a er Can Cly week /Medical resulling in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Day Year 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 (No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 **(1)**(No After this certificate 1 Yes completely filled in by the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours efter deatl To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Furkas

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie U U O Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2006 Dixon November 21:25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Ft. Washington Hospital Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 12 5. Social Security Number 7. Age (In yrs. last birthday) 33 yrs 9. Birthplace (State or Foreign **Funeral** Days Min. 214-19-8038 1 X M 2 □ F 1973 Washington, DC Director Yrs Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Int: if item 27 is marked other than "natural", or items 23s or 28s-f show may no other traumatic event. Its Medical Exammer must be notified at my or other traumatic event. Its Medical Exammer and 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD 1 X Yes 2 □ No Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2701 Tree View Way USA 20744 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2K No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Accountant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Holliman Dorothy Mae Boyd ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Tree View Way, Ft. Washington, MD 20744 Joyce Dixon/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: if any njury or once. Harmony Memorial Park 12/01/2006 Landover, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Figure 1896 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician vicular disease or condition resulting in death) nihute /Medical Due to (or as a consequence of) Examiner 15 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed nding physician and use as the burial-translt VIC. resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4

Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Tyes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: Other: 1 Yes 2 No P 1 🔲 Inpatient 2 ER/Outpatient 3FLDOA 4 Nursing Home 5 Residence 6 Other (Specify) After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide within 24 hours a 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CP.



31. Date filed (Month, Day, Year)

NOV 3 0 2006

32. Registrar's Signature

Nancy J. Davenport, M.D. 3301 New Mexico Ave., NW Suite 202 Washington, DC 20016

40095 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 7:20 AM Patricia McCloskey Donnelly November 24, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12400 Sarah Lane Bowie Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Yrs. 06/22/1930 76 Pennsylvania Director 196-22-8661 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or itsms 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Maryland Prince Georges Bowie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 12400 Sarah Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) DC Public School 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil ment of Health and Mental H tant: If ttsm 27 is marked off jury or other traumatic sven Katherine McAleer Hugh McCloskey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12603 Knowledge Lane Bowie, MD 20715 Dennis Donnelly/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Buriaf 2XX cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department o Important: If any injury or ottes. 11/27/2006 4 Donation 5 Other (Specify) Huntt Crematory Waldorf, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHYTHMIA-CARDIAC **Physician** disease or condition resulting in death) /Medical HEART FAILURE Examiner SVIRESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ WETTHOS. STROKE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown BLOOD 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2×300 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: ဥ 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Naturaf 5 Pending 1 ☐ Yes 2 ☐ No Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only 29c. License number 29b. Signature and title of ce 29d, Date signed (Month, Dav. Year) 3US 2 Sankineni-Janardhan Rao 30. Name and address of person who completed cau 4000-Mi 31. Date filed (Month, Pay,

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Bgistrar's Signature

2006

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			14	m
2-2	U	\cup	-	-

		1	For Stata Registrar	State of Marylan			of Health al	na Mentai F	iygieņ Røg. N		40030
			1. Decedent's Name (First, Middle, Last)					2. Date of Month		Day Year	3. Time of Death
	Physicia /Medic	al -	Marylou	Drur	У	4b Ciby T	own, or Location of	Novem	ber	24 2006 4c. County of Death	3:45 p M
	Examin	er	4a. Facility Name (If not institution, give s					Doam			_
			230 Sandcastle E 5. Social Security Number 6. Sex		last birthday)	If Under	iitland 1 Year If Under 2	4 Hrs. 8. Date of	Birth	Wicomic 9. Birth	O place (State or Foreign ntry)
	Funeral Director			M 21√2 F 73	Yrs.	Months	Days Hours	Min. Sept	Day, Yea		t Virginia
		-	Usual Residence of Decedent			LL			20 1	733 NCS	· viigiliia
	yiang		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Mar Mar	to	MD Wicomico	F	ruitlaı	nd					1 □ Yes 2 □ No
	7.28	Funeral Director	10e. Street and Number			10f. Zip	Code		10g. 0	Citîzen of What Cou	ntry?
	1 wit	ai	230 Sandcastle Blv	√d.			21826			USA	
	deal deal	ner	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Deced	ent of Hispanic Orig ify Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri Black, White	
21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. It was not other than "natural", or items 23s or 28s-f show event, the Madical Examination at	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes ②XX No If Yes, Give Year or Dates:		1□Yes 2					White
ğ	2 hou	ted	15. Decedent's Educ		16a. Dece	dent's Usua	I Occupation	of working	16b.	Kind of Business/Ir	dustry
212	nin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	k doné during most e retired)	Of WORKING			
7	d with	mo:	11		CNA					Medical	
ğ	e filed within al Hygiene. I other than vent, II: M	BeC	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Mic	ldle, Maid	len Sumame)	
Maryland	2 should be and Mental is marked o	To E	James E. Farley					iney Mill			
<u>a</u>	and s m		19a. Informant's Name/Relationship (Typ							y or Town, State, Zi	
	of Health of Health litem 27 i		Curtis Drury (Son)		_				-	, MD 2106	
ore	of Ho		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	1	Place of Dispo cemetery, crei			Date	20c.	Location - City or T	own, State
Ĕ	Pag ment ant: I ury o		' 4 Donation 5 Other (Specify)	Ep	iphany	Episo	copal	11-28-200	6 0	denton, M	D
Baltimore,	permit. Pages 1 Department of h Important: If ite any Injury or ot once.		21. Signature of Funeral Service Company	98	22	Harde	d Address of Facility Sty Fune	ral Home.	P.A	is, MD 21	401
			23a. Part1. Enter the disease, or compli	cations that caused the deat	h. Do not ent	ter the mode	of dying, such as o	ardiac or respirato	ry arrest,	1.5 PIU 2	Approximate Interval Between
			shock, or heart failure. List only on Immediate Cause (Final	CONTRACTOR SERVER	10 1		- 00010	co			Onset and Death
	mysician /Medical		disease or condition resulting in death)	Due to (or as a consec		MAG	a CANO	ren .		-	
	Examiner			COPD	,						
		ē	Sequentially list conditions, if any, leading to immediate	Dies to (or as a consec	wanna of):						
	uted d ansit	声	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć.	exector and and ital-tra	Examiner	resulting in death) Last	Due to (or as a consec	quence of):						
68760,	icate be executed physician and s the burial-transit	edicai		I							
w		ledi									
Вох	leath certific attending pl	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		⊒Ectopic pr	egnancy			23d. Date of deliv	ery Day Year
	deat	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (sp				Month	Day real
Q.	at the de by the a stached	h	9 🗆 Unknown						N. al. A. al	co use contribute to	she accorded death?
	The law requires that the death certif ale has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	inderlying ca	ause given in Part I.		,		bably 4 Dunknown
בֻ	w require	ted							M 162	2 110 3 110	Dabiy 4 Donkhown
Records,	law rias be	Completed						a	Vas an utopsy	prior to c	opsy findings available ompletion of cause of
<u> </u>		Con							erformed es 2 12		2 No
Vita	iffic for,	Be (25. Was case referred to medical examiner?					of Death (Check of	nly one)		
of <	nysici, nis cer I direc	2	1 ☐ Yes 2 ☐ No	fospital: 1 Inpatient 2	ER/Outpatre			3		6 ☐ Other (Spec	ify)
0	ding Ph h. After th funeral	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?		ibe how ir	njury occurred	
<u>Ö</u>	ttendin death. ctor: Aft y the fur	atic	2 Accident investigation			М	1 ☐ Yes 2 ☐ N				
Division	I or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory	r, office		on (Street Town, St	t and Number or Rui tate)	al Route Number,
	pital urs a eral E		200 Carifics 1 Destituing Phys	sician: To the best of my kn	owladaa daal	th agains d	at the time, date and	d place, and due to	the cause	a(s) and manner as	stated
	To the Hospital within 24 hours and the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	ner: On the basis of examination and manner stated.	ation and/or in	nvestigation	, in my opinion, deat	th occurred at the ti	me, date	and place, and due	to the cause(s)
	ro th Mithin To th	Me	29b. Signature and title of certifier				. License number		29d.	Date signed (Month	
	> - 0		M. M.	D			176343	3		11/25/6	>
	e f		30. Name and address of person who co		m 23a) (Type,	, Print)	\$ Table 1				50
	4		NEHAL DOSHI	106 MILFORI	ST.	#501	4BISAL	SBURY	MD	21804	
	Sta	ate	31. Date filed (Month, Pay, Year)	32. Registrar's Sign	ature	1 .					

			1 - For Stata Registrar	State of	Maryland		artmen rtificat			and M		Reg. No.	006	40097
	Physici /Medic	al	Decedent's Name (First, Middle, Las Mary Ellen Dow As, Facility Name (If not institution, give	ms	er)		4h City	Town or	Location	of Death	2. Date of De Month Novemb	per ^{Day} 28	, 2006 inty of Death	3. Time of Death 5:10A. M
	Examin	er	Renaissance Gardens at 5. Social Security Number 6. So	Riderwood				lver	Spri	.ng	8. Date of Bir	Pri	nce Ge	orge's
	Funeral Director			□M 2 X F		7 Yrs.	Months	Days	Hours	Min.	8. Date of Bir Monto, Da May 12	,°1′9°0′9		šýlvania
	Maryland R-f show ilied at	tor	Maryland Montgome	ery		Town or Lo		ng					1	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28 ist be not	ai Dire	10e. Street and Number 3112 Gracefield H	Road, PV21	14		10f. Zip 20	Code 904					of What Cour ed Sta	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show principly or other treumatic event, I've Medical Exattate Lividia Lividia at another.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married T Widowed 4 Divorced	12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	es? ENo	- (Was Decec If Yes, spec	**	spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White, acify: Wh	
21215-0036	od within 72 h giene. er then "natu	Completed	15. Decedent's Ec (Specify only highest gra		or 5+)	life.	dent's Usua kind of woi DO NOT us emake	rk done d se retired,	luring mos.			OW	n home	dustry
/land	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, The Men	To Be (17. Father's Name (First, Middle, Last) Albert H. Beldin	ng		,					(First, Middle, Caufie.		name)	
, Man	ss 1 and 2 sho of Health and litem 27 Is mu r other treums		John F. Downs -son	,, ,		4 Cre	scent	Roa	d, Uni	LtD (reenbe	lt, Ma	ryland	20770
Baltimore, Maryland	permit. Pages 1 Department of He Importent: If iter eny injury or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)			coln	Ceme	tery	12/2	2/2006	Brent		Maryland
Ball	permit Depart Import eny in			romas		4	400 P	owde	r Mil	LI KC		LSVIII	e, PA e, Mar	yland 20705
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Chror Due to (or	nic Obs	truct:						rrest,		Approximate Interval Between Onset and Death
c 68760,	iaw requires that the death certificate be executed us been signed by the attending physician and 2 should be detached for use as the buriat-transit	Medicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	d	as a consequ									
P.O. Box	that the death certific led by the attending pl detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3[Ectopic pr Other (sp					23d.	Date of delive Month	Pry Day Year
ecords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions of Cor Pulmonale; Co					ause give	en in Part I.			obacco use c Yes 2 □ No		ne cause of death?
\mathbf{x}	: The law rek cate has bee ; page 2 shoi	Completed									24a. Was autor perfo 1 \(\text{Yes} \)		prior to cor death?	psy findings available mpletion of cause of 2 No
of Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} 2 \(\text{No} \)	Hospital: 1 ☐ Inp	patient 2 🗆 l	ER/Outpatier	nt 3 DC	Othe	30		n <i>(Check only c</i> ome 5 ☐ Resid		Other (Specifi	v)
ion o	fter fter	ation: T	27. Manner of Death 1X Natural 5 Pending 2 Accident investigation		Injury Day Year)	28b. Time o Injury	f 2	8c. Injury Work	rat (? Yes 2 🔲		28d. Describe	now injury oc	curred	
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	f Injury - At ho , etc. <i>(Specify</i>		eet, factory	r, office			28f. Location (City or Tou		mber or Rura	l Route Number,
	e Hospi 24 hour e Funer letely fill	Medicai	29a. Certifier (Check only one) 2☐ Medical Exam	ysician: To the be niner: On the bas and manne	is of examinat	wledge, deat ion and/or in	h occurred vestigation	at the tim , in my op	ne, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and date and plac	manner as st ce, and due to	ated. the cause(s)
)	To the To the To the Comp	Me	29b. Signature and tyle o certifier	الم				2403					ned (Month, ber 28	
(3		30. Name and address of person who Eugenio S. Macha	do, M.D.	of death (Item 3110	23a) (Type, Gracef	Print) ield	Road	Silv	ver S	Spring,	Mary1	and 20	904
	Sta Registi		31. Date filed (Month, Day, Year)	2006	pistrar's Signat	ure	male							

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			1 - For State Registrar	State of Ma	rylanu / L		cate of	neaith and iv Death	ientai Hy	/giene Reg. No.	06	40098
	Physici /Medi		1. Decedent's Name (First, Middle, I	DEVEN	EY				2. Date of Do Month	eath Day	Year 2406	3. Time of Death
Ì	Examir	ner	4a. Facility Name (If not institution, g		ST HOS			er Location of Death	truc		y of Death	ren'y
100	Funeral Director		5. Social Security Number 6. 215 - 38 - 5740 Usual Residence of Decedent	Sex 1 M 2 F 7. Age	(In yrs. last bir		Under 1 Year Inths Days	Hours Min.	8. Date of Bi (Month, Do NOVEMBER	rth a <i>y, Year)</i> 23 , 1921	9. Birthpli Count SCO	lace (State or Foreigr try) DTLAND
	ryland how	_	10a. State 10b. County		10c. City, Tow	n or Locatio	n				10	0d. Inside City Limits
	the Ma 28a-f s	Director		GOMERY			ILVER SI	PRING				1 ☐ Yes 2 L No
	h with 3a or st be n		10e. Street and Number 3148 GRACEFIELI) ROAD		10	of. Zip Code 20	904		10g. Citizen of U.S.		ry?
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:			Decedent of H s, specify Cub es 2\lefta\ No	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	o- 14. Rad	ce - America ck, White, e	
2-0	n 72 ho "natur edical	Completed	15. Decedent's (Specify only highest of	Education rade completed)	16a.	(Give kind	Usual Occup of work done	during most of worki	ng	16b. Kind of B	usiness/Indi	ustry
2121		ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		OT use retired HINIST	d)		UNIVERS	ITY OF	MARYLAND
nd	ould be filed Mental Hyg arked other atic event, t	BeC	17. Father's Name (First, Middle, Lat	st)				18. Mother's Name	(First, Middle			
Maryland	ould b Ment arked	10	WILLIAM DRUMMOND I						MOORHEAD			
Mar	d 2 sh th and 7 is rr traum		19a. Informant's Name/Relationship ANNALISA COOPER		19b			and Number or Rura			State, Zip (Code)
	s f and 2 should f Health and Men Item 27 is marke other traumatic		20a. Method of Disposition	DAUGHIER	20b. Place of	Disposition	(Name of	DRIVE, DEALI	E, MARYL	AND 20751 20c. Location	- City or Toy	vn State
e E	nit. Pages artment of ortant: If I: Injury or o		1 Burial 2 □Cremation 3 4 □Donation 5 □Other (Spec		1	-	y or other place TON CEMI	^{ce)} ETERY 12/2/	2006		-	
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Lo	ensee	- CHOICE !	22. Nar	ne and Addre			ADELPHI,		
Ī			2 a. Part1. Enter the disease, or co shock, or heart failure. List only	nplications that caused the course of the cause on each line	ne death. Do r	not enter the	mode of dyir	ng, such as cardiac o	r respiratory a	vek SPRING		Approximate Interval Between
k	Physician		Imme la e Cause (Final disease or condition resulting in death)	a. ACUITE	PULM	NONA	ry E	Toma	WITH			Onset and Death
	/Medical Examiner			CARDID			tock)•				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of	of):						
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. EXTENS	IVE	INTE	nopos	TERIOR.	INTER	OLATE	USI	
8760,	be exician a		Todaling in death, East	Due to (or as a	consequence of	of):	NYOCAY	COIAL I	MARK	nm		
/89	rtificate ng phys as the	Aedical		La SEVERCE	LE	ETM	MILLE	DISEACE	st, m	VILTIPLE	= VES	SELS
O. BOX	ath cer attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	pregnancy Fetal death	3 □Ecto	pic pregnancy er (specify)			1	te of delivery	y Day Year
cords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but	not resulting in	the underly	ing cause give	en in Part I.		obacco use cont Yes 2 No	ribute to the	cause of death?
Hecol	e la has	Completed							24a. Was	an 24b.	Were autops	sy findings available pletion of cause of
Vital	ician: The certificate ha ector, page		25. Was case referred to medical	Т						2 No	death? 1 ☐ Yes 2	.□ No
	S 0 =	o Be	examiner?	Hospital: 1 Inpatient	2 ER/Out	tpatient 3	DOA Othe	26. Place of Death er: 4 ☐ Nursing Horr			or (Coorie)	
<u></u>	D 0 0	T:uC	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	28b. T		28c. Injun Work			how injury occurr		
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral presents.	Certification:	2 Accident investigatic 3 Suicide GCould not I 4 Homicide	e Osa Diaga of inium	- At home, far	M	10	Yes 2 □ No	8f. Location (8 City or Tox	Street and Numb vn, State)	er or Rural I	Route Number,
	he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying P	hysician: To the best of a miner: On the basis of e and manner state	xamination and	, death occu d/or investig	irred at the tin ation, in my o	ne, date and place, a pinion, death occurre	nd due to the	cause(s) and ma date and place,	nner as stat and due to t	led. he cause(s)
1		Σ	29b. Signature and title of certifier	n, ard	, Fit	u	29c. License	0.76/1	5	29d. Date signed	1 (Month, De	ay, Year) 2006
	10		30. Name and address of person who	completed cause of deal	th (Item 23a) (T	Type Printy	Gorgon	iav. Ferr	er M.	Park	, mx	2091:
İ	Sta Registr		31. Date liled (Month, Day, Tear)	Pegistrar's	Signature	park	P					

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State of Maryland / Department of Health and Mental Hygiene 0

1 - For State Registrat Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 29, Physician 2006 05:30 A M DALLAS ELLWOOD DAVIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHESTERTOWN NURSING & REHABILITATION KENT CHESTERTOWN If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ★M 2 ☐ F Months Hours 0972071929 MD 77 217-30-4135 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and to I health and Mental Hygiene. ant: If item 27 is marked other then "natural", or Items 23a or 28a-1 ehow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 27 is marked other then "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Exemple mast be notified at 1 Yes 2 No CHESTERTOWN QUEEN ANNE'S MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 257 DUKE OF KENT STREET 21620 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. Specify WHITE 1 □ Never Married 2 N Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. POSTAL SERVICE EXECUTIVE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FLORENCE AGNES THOMAS ROBERT E. DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 257 DUKE OF KENT STRET, CHESTERTOWN, MD 21620 PEGGY S. DAVIS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
ony injury or ot 1 Burial 2 Cremation 3 Removal from State LAKEWOOD GARDENS EAST 12/04/2006 CHATTANOOGA, TN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Deathy 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final - mmthe Remar 3 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ and for 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 100 1 ☐ Yes Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 66 mo 17036 400 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) 8 Chartentown Mu 21620 Woshington Ross m.D. 5/6 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2006 Registrar

DHMH 17 Rev 1/200

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Louella F. Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4c. County 4b. City. Town, or Location of Death Examiner Peninsula Kegional Medical Center Salisbury Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2 🗵 F Director 084-12-9840 85 09/18/1921 Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10a State or 28e-f show other treumetic event, the Medical Examiner must be notified at Director Florida Santa Rosa Milton 10g. Citizen of W 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itema 23a any injury or other treumatic event, the Medical Englishmett 5945 Ridgeview Drive 32570 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Elwards Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Bu Elementary/Secondary (0-12) College (1-4or 5+) 8 Waitress Restaura 18. Mother's Name (First, Middle, Maiden Sumame 17. Father's Name (First, Middle, Last) Be Herman Reim Pauline Reim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 5 Carol Carleton/Daughter 14612 Carleton Lane, Eden, MD 21822 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location -20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 12/03/2006 Salisbur Hinman Funeral Home M00295

H1nman funeral Home
11673 Somerset Avenue, Prince
134. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11673 Somerset Avenue, Princess Immediate Cause (Final disease or condition resulting in death) difficite clostindia Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the attending physician and the dor use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) detached 9 I Inknown 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please 1	Type or Print i				-			1.01	01
	State of Mary			of Death	vicillal F	Reg. No.	2000	70	U (
, Middle, Last	")				2. Date of Month		Vana	3. Time of Dea	ath
Edwar	ds				12	O ₂	Year 06	1034	М
stitution, give	street and number)		4b. City, Tox	vn, or Location of Death			County of Death		
eg10/19	1 Medical (Tenter	Sa	lisbury			Wicomi	CO	
	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.		Birth Day, Year) 8/1921		place (State or Fo ntry) York	oreign
County	100	c. City, Town or Lo	cation					10d. Inside City Li	
nta Ro	sa	Milton						1XYes 2	□No
			10f. Zip Co	de		10g. Citiz	zen of What Cou	ntry?	
view D	rive		32	2570		US	SA		
	12. Was Decedent Ever	in U.S. 13.	Was Deceden	of Hispanic Origin? (S)	pecify Yes or	No-	14. Race - Ameri		
☐ Married vorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 Yes, specify	Cuban, Mexican, Puert No Specify:	o Hican, etc.)		Black, White, Specify: W	hite	
ecedent's Edu	ucation	16a. Dece	dent's Usual C	ccupation	lein n	16b. Kir	nd of Business/In	ndustry	
0-12)	de completed) College (1-4or 5+)	life.	DO NOT use i	lone during most of wor etired)	king				
	none	Wa	itress			Rest	aurant		
Aiddle, Last)				18. Mother's Nam	ne (First, Mide	dle, Maiden	Sumame)		
				Pauline	Reim				
lationship (T)	ype, Print)	19b. Maili	ng Address (S	treet and Number or Ru	ral Route Nur	nber, City or	Town, State, Zij	o Code)	
ton/Da	ughter	1461	2 Carle	eton Lane,	Eden,	MD 218	322		
	. 2	Ob. Place of Dispo cemetery, crei			Date	_	cation - City or To	own, State	
	nesilovai iloili State			, ·	2/2006	0.1.		v 1 1	1
her <i>(Specify)</i> erv <i>i</i> ce Licens				tory 12/0		Sali	sbury,	Maryland	
e. List only o	lications that caused the one cause on each line. a	death. Do not ent	er the mode o	omerset Average of dying, such as cardiac			ss Anne	Approximate Interval Betwee Onset and Deat	อก
⁴⊀	b. — Due to (or as a co	nsequence of):							
	Due to (or as a co	nsequence of):							
d. 23c. If yes, outcome of pregnancy 1								ery Day Year	r
,	ontributing to death but no	ot resulting in the u	nderlying caus	e given in Part I.	23e. D	id tobacco u	se contribute to t	the cause of death	h?
act 11	rection				1	□Yes 2	No 3 □ Prol	bably 4 Unkr	nown
rellitus					_ pe	itopsy orformed?	prior to co death?	opsy findings avai	ilable e of
nodical				OC Place of Page	1 Ye		1 🗆 Yes	2 No	
nedical	26. Place of Death (Check only one) Hospital: 45 Particle 45 Positions 45 Position								
	28a. Date of Injury	2 ER/Outpatier		4 Nursing n		esidence 6 oe how injury	Other (Special	ry/	_
Pending investigation	(Month, Day Ye	ar) Injury	M	Injury at Work? 1 ☐ Yes 2 ☐ No	•	oo now injury	Cocumbo		
Could not be determined	28e. Place of Injury - building, etc. (S	28f. Location (Street and Number or Rural Route Number City or Town, State)				1			
ertifying Phy edical Exem	ysician: To the best of my iner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at t vestigation, in	he time, date and place my opinion, death occu	, and due to t rred at the tim	he cause(s) ne, date and	and manner as s place, and due to	stated. o the cause(s)	
certifier	and marmor stated.		200 1	icense number		29d Date	e signed (Month,	Day, Year	
222	7		29C. L	1		250. Date	Jagned (Month,	/ / rear)	

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 5 Pending investigation PSNatural 2 Accident 6 Could not be 3 Suicide determined 4 Homicide Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and man 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. 29a. Certifier 29b. Signature and title of certifier mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Silva Sv m D Peninsula Charles

mellitus

1 - For State Registrar

31. Date filed (Month, Day, Year) DEC 0 6 2006 32. Registrar's Signature

State Registrar

To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifice

within 24 hours a To the Funeral L

Completed

Be

2

Certification:

		•	for Stete Registrar	State of Marylan		tificate of			g. No.		
			Decedent's Name (First, Middle, Las	it)			12	2. Date of Death Month	1	3. Time of Death	
	Physici /Medio		20NALE	EAST	ERD	AX		W07		2006 02) & WA	
	Examir		4a. Facility Name (If not institution, give				or Location of Death		4c. County o		
			LAUREL REGIONAL			LAUR			PRINC	E GEORGE'S	
	Funeral Director		5/8-42-1/08	ex 7. Age (In yrs. 72	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Repair of the Hours Min.	B. Date of Birth (Month, Day, UGUST 2	6 1934	9. Birthplace (State or Foreign Country) WASHINGTON, DC	
	and and	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits	
	within 72 hours after death with the Maryland ane. than "natural", or iteme 23s or 28e-1 show ns Medical Examirar must be notified at	Funeral Director	MD PRINCE G	EORGE'S	BELTSV	ILLE				1 X Yes 2 □ No	
	iff th	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?	
	ath w	rai	11222 EVANS TRAIL			20705			U.S.A.		
	er de	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of F Yes, specify Cub	dispanic Origin? (Spec an, Mexican, Puerto Ri	ify Yes or No- ican, etc.)		- American Indian, , White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes Give	avy	□Yes 2🏞 No	Specify:		Specify:	WHITE	
21215-0036	thou sture	edi	15. Decedent's Ed	Year or Dates: 9-52-	16a, Decede	ent's Usual Occup	pation	1	6b. Kind of Bus	iness/Industry	
15	n ne	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give k life. D	ind of work done O NOT use retire	during most of working d)	7		,	
212	d with	E	12th	College (1-401 5+)	DISAB	LED			NONE		
פ	e filed value Hygie other t	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name ()	
<u>a</u>	uld burkents	일	GEORGE CLAYTON				MARY F	. BAKER	L		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ADGE.		19a. Informant's Name/Relationship (7 ROBERT C. EASTER				and Number or Rural RAIL BELTSV				
altimore,	s 1 a of Hea	1	20a. Method of Disposition		Place of Dispos	ition (Name of atory or other pla	Ce) Da	te 2	0c. Location - C	City or Town, State	
Ĕ	Page nent c int: If		1 ☐ Burial 2 ♣ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-	CREMATO		006 R	IVERDAL	E, MARYLAND	
a a	permit. Departmimporte		21. Signature of Funeral Service Licen	See.	22.	Name and Addre	ess of Facility J.	B. JENI	KINS FU	NERAL HOME	
m	88 = 8		* S. M-	hall	74	474 LAND	OVER ROAD				
			23a. Part1. Enter the disease for comp shock, or heart failure. List only	dications that caused the deat	h. Do not ente	r the mode of dyir	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition ACUTE PULMONARY EDEMA								
	/Medical		resulting in death)	Due to (or as a conseq							
	Examiner		Coquentially list conditions	CORONARY AR	TERY DI	SEASE					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. PNEUMONIA							
ő	e exe		resulting in death) cast	Due to (or as a conseq	uence of):						
68760,	tificate be executed ig physicien and as the burial-transit	Medicai	•	d. SEPTICEMIA							
		Me	IF FEMALE:	20- 16							
Вох	death cer e attendin id for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ıl death 3 □E	Ectopic pregnancy	y		23d. Date Mont	of delivery h Day Year	
P.O. B	D 0 D	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	leath 5∐	Other (specify) _					
	The law requires that the de ste hes been signed by the a bage 2 should be detached f		Part II. Other significant conditions of	ontributing to death but not res	ulting in the unc	deriving cause giv	ven in Part I	23e. Did toba	acco use contrit	oute to the cause of death?	
Division of Vital Records,	signe d be	1 by	DIABETES MEL		3	,g g				B ☐ Probably 4 ☐ Unknown	
Š	w require been si should b	Completed	AUDTAT DEDDT	I I ATTON							
ě	hes hes	ш	ATRIAL FIBRI	LLATION				24a. Was an autopsy perform	pr	ere autopsy findings available for to completion of cause of eath?	
e e	ysicien: The lav is certificete hes director, page 2		PERIPHERAL A	RTERIAL DISEAS	E			1 ☐ Yes 2	∑ No 1 [☐Yes 2X No	
₹	sicie	Be	examiner?	Hospital:	IED/0	or so Ott	26. Place of Death (
ō	Phy r this	2.10	1 ☐ Yes 2X No 27. Manner of Death	1 Nnpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injur	4 Nuising Home	d. Describe hov			
0	r Attending Physicien: for death. Irector: Affer this certifics I by the funeral director. I	to	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		rk? Yes 2∐No				
/ISI	or Attendent efter death Director: in by the	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury - At no	ome, farm, stre	et, factory, office	28			r or Rural Route Number,	
á		Certification:	4 Homicide	building, etc. (Specif	y)			City or Town,	State)		
	Hospital 24 hours e Funerel i tely filled	alc	29a. Certifier 1 Cartifying Ph	ysician: To the best of my kno	wledge, death	occurred at the tir	me, date and place, an	d due to the cau	use(s) and man	ner as stated.	
	To the Hospital or within 24 hours effet To the Funerel Dir completely filled in	edical	(Check only 2 Medical Examone)	ninar: On the basis of examina and manner stated.	ition and/or inve	estigation, in my o	opinion, death occurred	at the time, dat	te and place, ar	nd due to the cause(s)	
	To the within 2 To the complet	≥	29b. Signature and title of certifier	ATTEND	in G	29c. Licens	se number	29	d. Date signed	(Month, Day, Year)	
	. 61) seese	- PHYSICI	07 FN	200	05721(0 1	10V >	18, 2006	
1/	[[3) [C	30. Name an address of person who do box I CHAEL BAR	completed cause of death (Iter	п 23а) (Туре, Р	rint)	saw na	A some	, U- h	20707	
1	-01	M				I DIV	ا رفضہ! ۲۰۰۰	- MILE	m, Tres	, 10/4/	
	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	•					
01.	Regist	ar	NOV 3 0 2006	Devent D.	oper						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 006

		•	1 - State Registrar		Ce	rtificate of	Death	Re	g. No.			
	Dhysiai	20	1. Decedent's Name (First, Middle, Las					2. Date of Death Month		3. Time of Death		
	Physicia /Medic		MARY O.	ETCHELLS					R 28, 2006			
	Examin	er	4a. Facility Name (If not institution, give	street and number)		EAS			4c. County of Death	1		
	Funeral Director		5. Social Security Number 6. S 554–30–9467	ex 7. Age (In y	rs. last birthday Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, JAN 30,	9. Birti	nplace (State or Foreign untry) RYLAND		
and	3		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits		
Manyl	oh e la	5	MD TALBO		EAS'					Yes 2 □ No		
the	28a-	Director	10e. Street and Number	<u>*</u>	Epct.s7.	10f. Zip Code		10	g. Citizen of What Co	untry?		
h with	3a or		49 DAVIS			2	1601		USA			
deat	E LUI	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	. Was Decedent of I	Hispanic Origin? (S van, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White			
urs after	and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f ehow eumatic event, tre Medical Examiner must be mutified at	þ	1 ☐ Never Married 2 ☐ Married 3 🗶 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 □ Yes 2 X No				HITE		
72 ho	natur	eted	15. Decedent's Ec		(Giv	edent's Usual Occu e kind of work done	during most of wor	king 1	6b. Kind of Business/	ndustry		
within	iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	nd)		WOMEN'S SP	ORTSWEAR		
D E	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	aiden Sumame)			
uld bu	Menta irked itic ev	To E	TIMOTHY O'TOOLE				MARY	LURZ				
2 should	f Health and Men Item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Stree	t and Number or Ru	ral Route Number,	City or Town, State, 2	ïp Code)		
2 0	₹ P =		TIM ETCHELLS/SON			PAINTER position (Name of	RD., MIDI	Date 2		Favor Chata		
mit. Pages 1	Department of Heal Important: If Item 2 any injury or other 2006.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content o	Removal from State	cemetery, cre	ematory or other pla			Oc. Location - City or OXFORD, MA			
permit.	Departn Imports any inju		21. Signature of Funeral Service Licer						AM FUNERAL	HOME PA		
			23a, Part1, Enter the disease, or com-	MERCE Ro		200 S. HA	RRISON ST	E EASTON, or respiratory arre	MD 21601	Approximate		
DH	nysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
6	Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	(10)) C	(Ac of c	VOSCULAR	(2/378/6	- yours		
E	xaminer		Cognostially list conditions	b								
D	Ħ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con-	sequence of):							
ecute	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a con-	soguence of):							
ficate be ex	icien			540 10 (0. 45 4 55	304401100 01).							
Certificate be executed	ing physicien and e as the burial-transit	Medical		d								
The law requires thet the death certi	been signed by the ettending should be detached for use a	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	ey .		23d. Date of deli Month	very Day Year		
het if	ad by detac	F.	Part II. Other significant conditions of	contributing to death but not	resulting in the	underlying cause g	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
requires	n sign							1 □ Yes	3 2 0 No 3 □ Pro	obably 4 Unknown		
5 §	s bee 2 shoi	plete						24a. Was an	24b. Were au	topsy findings available completion of cause of		
The	certificete has birector, page 2 s	Completed					·	autopsy perform 1 Yes 2	ed? death?	2⊟No		
<u> </u>	ctor. I	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one				
P ysic	this call dire	2	1 ☐ Yes 2 ☐ No		2 ER/Outpatie	STIL SLI DOA			nce 6 □Other (Spec	afy)		
ding F	After funera	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury							
or Attending Physician:	within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ertification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e Ole Class of Injury	At home, farm, s			28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,		
Hospital	Funerel Funerel ely filled	edical Ce	(Check only 2 Medical Exar	sysicien: To the best of my niner: On the basis of exam	knowledge, dea	ath occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the car irred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)		
the the	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.	,	29c. Licen	se number	29	d. Date signed (Mont)	ı, Day, Year)		
7	₹ 50		1	11//		D	31461		11/26/01			
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)	100		1/07/06	,		
				DER III M.D.			RIVE, EAST	rob, MD 2	1601			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's S			-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 11 State of Mary Registrar WCHD/SH 12/8/06 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 1, Ruth Ewart December 2006 12:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ravenwood Lutheran Village Hagerstown Washington 8. Date of Birth (Month, Day, Year)
Feb. 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1922 Pennsylvania **Funeral** Months Days Hours Min. 84 Yrs 220-18-0943 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Washington Hagerstown 1 ☐ Yes 2XXNo

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

32. Registrar's Signature

ORIGINAL

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any lnjury or other traumatic event, the Medical Examiner must han access to another. Baltimore, Maryland 21215-0036

Director

Funeral

þ

10e. Street and Number

17742 Virginia Avenue

4 Divorced

1 ☐ Never Married 2 ☑ Married

Physician /Medical **Examiner**

burial-tra physician the. use as signed by the a cate has funeral director. this within 24 hours after death

To the Funeral Director:

The law requires that the death certificate be executed

or Attending Physician:

SH-1

Division or Vital Records, P.O. Box 68760,

듗	15 Decedest's 5	duration	16a Dacadant's Havel Oss	mation	4.05	Kind of Duning	No. A. other			
ete	15. Decedent's E (Specify only highest gra	ade completed)	16a. Decedent's Usual Occi (Give kind of work don	e during most of working ed)	160.	16b. Kind of Business/Industry				
Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	housewife	66)		her own home				
ပ္	17. Father's Name (First, Middle, Last)		18. Mother's Name (F	irst, Middle, Maide					
To B	Harry	King		1		ane Pip	er			
-	19a. Informant's Name/Relationship (Candy Cline - gr		19b. Mailing Address (Street							
	20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory 2006 20c. Location - City or Date December 2, Hagerstown, Crematory									
	21. Signature of Funeral Service Lice	nsee	22. Name and Add	ress of Facility Minn	ich Fune	ral Home				
	Fred L. V.	util	415 East	Wilson Blvd	., Hager	stown, M	aryland 2174			
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the dear one cause on each line.	th. Do not enter the mode of dy				Approximate Interval Between Onset and Death			
	disease or condition resulting in death)	a. Alluworos	desotic Con	dio voscul	en des	Cerese	5year.			
		Due to (or as a consec	quence of):	4.1			- 0			
er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	Juence of):	va.			years.			
E.	cause. Enter Underlying Cause (Disease or injury	0								
Exa	that initiated events ' c									
by Physician/Medical Examiner		d								
Mec	IF FEMALE;									
ian/	23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1									
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5 Other (specify)			Month Day Year				
된	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to	the cause of death?			
ted b					1 Tes	2 No 3 Pr	robably 4 Nnknown			
plet					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of			
Completed					performed? 1 Yes 2 N	death?				
Be (25. Was case referred to medical examiner?			26. Place of Death (C	heck only one)					
2	1 Yes 2 No		ENOutpatient 3L DOA	ther: 4 Nursing Home	5 Residence	6 □Other (Spe	cify)			
tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M 28c. Injury M	ury at 28d. ork? ☐ Yes 2 ☐ No	. Describe how inj	ury occurred				
tifica	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At h building, etc. (Specia	ome, farm, street, factory, office fy)	28f.	Location (Street a City or Town, Sta		ural Route Number,			
S										
edical Certification: To	29a. Certifier 1/1 CertifyIng Pt (Check only 2 Medical Exal one)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurred at the ation and/or investigation, in my	time, date and place, and opinion, death occurred a	due to the cause(at the time, date a	s) and manner as nd place, and due	s stated. e to the cause(s)			
Ž	29b. Signature and title of certifler	N 0.	29c. Licer	se number	i	ate signed (Mont	th, Day, Year)			
	I May gon	y/maj	\mathcal{D}	28365	1.	2-1-06				
	30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	14 1- 11	210 1	Par.	02/2:			
	MAW 2 All.	JSHAFI	368 null	Street- He	rgesten	m 171	14140			
6	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		~					

10f. Zip Code

1 ☐ Yes 2X No

21740

13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

10g. Citizen of What Country?

U.S.A.

14. Race - American Indian, Black, White, etc.

Specify: white

DHMH 17 Rev 1/2001

State Registrar

For	State of Maryland / Department of Health and I
State Registrar	Certificate of Death

40104

			1 - State Registrar				Cer	tificate of	Death	Re	g. No.	0.0	7010.
	Dhysiai	an	1. Decedent's Name (Fi	irst, Middle, L						2. Date of Deat		Year	3. Time of Death
	Physici /Medio		CARLTON	L.	FOSTER					DECEMBEI	R 3', 2	006	10:33 A M
de la	Examir	er	4a. Facility Name (If not	_					or Location of Dea			nty of Death	
			300 COUNTS. Social Security Numb			//a.un lank	Sint do. I	If Under 1 Year	RASONVILI			EEN AN	
	Funeral Director		216-12-103 Usual Residence of Dec	5	1 X M 2□F	e (In yrs. last	Yrs.	Months Days			Year)	MARYI	lace (State or Foreign htry) .AND
	/land			b. County		10c. City, To	own or Lo	cation				1	0d. Inside City Limits
	death with the Maryland ims 23a or 28e-f ehow rmust be notified at	ţo	MD O	UEEN AI	NNE'S	GRASO	NVIL	LE					1 ☐ Yes 2 X No
	or 28	Directo	10e. Street and Number		-			10f. Zip Code		10	0g. Citizen o	of What Coun	itry?
	23a c		300 COUNTRY	Y LANE				21638		U	SA		
Maryland 21215-0036	be filed within 72 hours after death with the Marylar lat Hygiene. d other then "naturel", or items 23a or 28e-f ehowent. The Madical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent I Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	lo	1	Vas Decedent of Yes, specify Cui ☐ Yes 2 X No	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ace - Americ lack, White, city:	etc.
Ç Q	72 ho	Completed	15.	Decedent's E				ent's Usual Occu	ipation a during most of wo	odvina	16b. Kind of	Business/Ind	
2	ithin	npie	Elementary/Secondar	, , ,	College (1-4or 5	+)	life. L	OO NOT use retir	ed)	iking			
2	filed w Hygier other th		12			R	EAL	ESTATE	T T			PLOYE)
and a	be fi	Be	17. Father's Name (Firs		t)					me (First, Middle, M	Maiden Suma	ame)	
ž	should be ind Menta marked umatic ev	ဥ	19a. Informant's Name		(Time Driet)		Ob. Mailia	- 4 / / 0 /	EVA CO		O'1 . T		2.11
<u>8</u>	nd 2 sl lith and 27 ie r r traur									ural Route Number,	•		
	1		MIKE FOSTE 20a. Method of Disposit	-	N	20b. Place	of Dispo	sition (Name of				n - City or To	E, MD 21638 wn, State
ᅙ			t XBurial 2 □ Cr 4 □ Donation 5 □		Removal from State			natory`or other pla	1				
Baltimore,			21. Signature of Funera			SIEVE	7	. Name and Addr	TERY 12/0	J6/2006 1	STEVEN	SVILLI	s, MD
ñ	permit. Depertr importe eny inje		1/km	an K	Helle his	el .	FE	LLOWS, I	HELFENBEI	N & NEWNA CHESTER,	M FUNI	ERAL H	OME, P.A.
Ī	Physician /Medical Examiner		23a. Part1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List ont	nplications that caused y one cause on each lir a Due to (or as	1	le v	er the mode of dy	ing, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
68/60,	death certificate be executed e attending physicien and ad for use as the burial-transit	Medical Examiner	Sequentially list condition in any, leading to immed cause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last	diate g y	b. Due to (or as a Due to (or as a d.								
O. Box 6	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	nths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnand Other (specify)	су		1	Date of delive Month	ry Day Year
2	thet I	Y Ph	Part II. Other significan	nt conditions	contributing to death bu	ıt not resulting	g in the ur	derlying cause g	ven in Part I.	23e. Did tob	acco use co	ntribute to th	e cause of death?
S	luires n sigr lld be	d by								1 □ Ye	s 2 🗆 🗀	3 Prob	ably 4 Unknown
Vital Records,	Physician: The law requires thet the this certificate hes been signed by th al director, page 2 should be detach	Completed								24a. Was ar autops perform 1 Yes 2	/	were autor prior to con death? 1 \(\sum \) Yes	osy findings available inpletion of cause of 2 No
II a	ertific ector,	Be	25. Was case referred t examiner?	to medical						ath (Check only one	9)		
	Physi this c	၉	1 Yes 2 100		Hospital:		Outpatien	3 DOA		lome 5 Reside			')
Division of	ing f	Certification:	2 Accident	Pending investigation		Year) 28t	o. Time of Injury	28c. Inju Wc M 1	ıryat ork?]Yes 2∐No	w injury occu	w injury occurred		
Ž O	P S S	Certifi	4 Homicide	determined		iry - At home, :. (Specify)	farm, stre	et, factory, office		28f. Location (Str City or Town		nber or Rura	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medicai	(Check only 2 one)	Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination:	ige, death and/or inv	occurred at the t estigation, in my	ime, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and n ite and place	nanner as st	ated. the cause(s)
ı	To the within 2 To the comple	2	29b. Signature and tifle	dicertifier	Cu				3LU3C		_	Y/)	
l	निर्द		30. Name and address	person who	completed cause of de	eath (Item 23a	(Type,	Print)	Dr.ve.	Charles	FIC IN	w 2	1419

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature 4 2006 DEC

State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0023 **Physician** Robert Bruce Fullerton Sr. November 28,2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Feb 21,1920 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours Min. 123-05-7167 86 Director Queens NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State ral", or items 23a or 28a-f show Examiner must be notified at Nueces Texas Corpus Christie 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 805 Egyptian Drive 78412 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural"; or iten ury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 XNo 1 ☐ Yes White Specify 3XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Fullerton Beatrice ဥ 19a. Informant's Name/Relationship (Type. Print)
Claire Vaillancourt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vaillancourt Fiance 805 Egyptian Court Corpus Christie ,Texas 78412 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 12-01-06 Succasunna Presbyterian Succasunna NJ 4 ☐ Donation 5 ☐ Other (Specify) 21401 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave ANN MD Dates 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ohysician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Year signed by the aid 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 21300 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner Joeath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 tural ours after death.
neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of confiner 29c. License number 29d. Date signed (Month, Day, Year) 00005829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Anne. Media ou runde 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygien 🗸 🕕 🖯 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician **FOX** BARBARA November 27 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EGS-ON If Under 1 Year If Under 24 Hrs. Mumorial HUSC 6. Sex 21taD Easton at 8. Date of Birth NOV. 29, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Country) Months 1 □ M 2 XX Yrs. 58 175-36-7033 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10b. Count in then "neturel", or iteme 23s or 28s-f show the Medical Examiner must be rightlifted at 1 ☐ Yes 2√ No Director EASTON TALBOT MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27461 TRAVELERS REST COURT 21601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give **X** Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 is marked other then "neturel", or 1□Yes 2□No Specify: WHITE 5 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) RETAIL STORE OWNER 12 $-\Omega$ -18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny lightly or other traumatic event pice. Be ဂ္ EDWARD DELP FLORENCE KONKALEWSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FOX / HUSBAND 27461 TRAVELERS REST COURT, EASTON, MD. 21601 JOHN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11-29-06 STEVENSVILLE, MD. CHESAPEAKE CRM. CTR. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FETTOWS Add HELFENBEIN & NEWNAM FUNERAL HOME P.A. Juseph m. Ustroush. 200 S. HARRISON STREET, EASTON, MD. 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) no Carculling **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 □-N6 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2∐ No Medical Certification; To 1 Tyes 1 1 impatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After t 1 Natural 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PS1293024 Db 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SMITH, M.D. 29466 PINTAIL DRIVE EASTON, MD. 21601 31. Date filed (Month, Day, Year). Begistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 3 0

			1 - For State Registrar	State of Maryla			of Deat			Rag. No.	Ub	40107
4	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
1000	/Medic	al	Magaline R. Gran			4h City To	own, or Location	on of Death	Novem		4 200 unty of Dea	06 9:30A M
	Examir	ier		ofton Convalescent & Rehab				AT OF DOGUT			e Arı	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	Crof	Year If Und	ler 24 Hrs.	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
Ľ	Director		213-20-0909	M 2X1F	77 Yrs.	Months [Days Hour	s Min.	Mar 1	9 192	9 N.	Carolina
-	pur *		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	cation						10d. Inside City Limits
	Aaryid Fahor	ō	Maryland Anne Art		rownsv							1 Yes 2 No
	28e-1	Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen	of What Co	
	with Sa or		1267 Sheridan Ro	٦		210					or what or	outility:
	ms 2	Funerai		2. Was Decedent Ever in	J.S. 13.			Origin? (Sp	acify Yas or No Rican, etc.)	USA 0- 14.		nican Indian,
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 Is marked other than "natural", or Items 23a or 28e-f show or other treumatic event, the Madical Examinar must be notified at	ρ	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		fYes, specify 1□Yes 挺			Rican, etc.)		Black, White ${ m B1}$ and ${ m B1}$	
ğ	2 hou	Completed	15. Decedent's Educ	ation	16a. Deced	dent's Usual (Occupation			16b. Kind (of Business	Industry
2	thin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	done during m retired)	lost of work	ing	Anne	Arur	ndel Co.
2	filed wil Hygien other the	Con	10th	0	Cu	stodi	an			Pub1	ic So	chool
<u>n</u>	be fill Hydrau d outh	Be	17. Father's Name (First, Middle, Last)						e (First, Middle	, Maiden Sui	mame)	
<u> </u>	should be ind Mental marked o	္	Sylvester Robins					ry He				
a N	12 sh h and 7 Is m reum		19a. Informant's Name/Relationship (Typ						al Route Numb			
O	1 and Healt em 2 ther		John L. Grant (Hi 20a. Method of Disposition		1267 Place of Discro	Sher	idan I		rowns			21032 Town, State
ခွဲ	nt of nt of t: If it		1X Burial 2 ☐ Cremation 3 ☐ Re	moval from State Me	Place of Diago cometary, cren moria	hatbry of other	er place) dens	11-3			.,	, Md.
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 It any injury or other tre		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License					:				
B	Deprime any conce		N	rese MOOYE	W	m. Re	ësë &	Sons	Mort	uary,	P.A.	
	F /9.		23a. Part1. Enter the disease, or complic	ations that caused the dea		21 We er the mode of	St St. of dying, such	 Ann as cardiac of 	apoli:	rrest,	. 214	Approximate
L. S.	Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (gras a conse	quence of):	acc	edust	<u>ا</u>				Interval Between Onset and Death
E. 2	不禁,	iner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a corrse	quenca of).							
oʻ	ificate be executed g physicien and as the buriat-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):							
68760	icate be physici s the bu	edlcai	d.									
_			IF FEMALE:									
O. Box	res that the death certi igned by the attending be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	 c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown 	al death 3	Ectopic preg Other (spec				23d.	Date of del Month	very Day Year
<u>a.</u>	The law requires that the tee has been signed by thoage 2 should be detache	h h	Part II. Other significant conditions cont	ributing to death but not re	sulting in the ur	nderlying cau:	se given in Pai	rt I.	23e. Did t	obacco use o	contribute to	the cause of death?
g	uires sign ld be	d by					-		1 🗆	Yes 2 N	o 3 □ Pr	obably 4 Unknown
Ö	w requ	Completed							24a. Was	an 2	th Were au	topsy findings available
He He	The lay	шc							auto		prior to death?	completion of cause of
Vital Records,			25. Was case referred to medical				ae Die	on of Dooth	1 Yes	2 No	1 🗆 Yes	2 No
	Attending Physicien: or death. ector: After this certifica by the funeral director, p	To Be	examiner?	spital: 1 Inpatient 2	TER/Outpatien	t 3 DOA	Out		me 5∐Resi		Other (Soo	264
<u>0</u>	ding Ph h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		28d. Describe			му)
<u>ö</u>	uttendin death. ctor: Afi y the fur	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Your)	Injury	М	1 ☐ Yes 2	□No				
Division of	i Pite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Spec	nome, farm, streify)	eet, factory, o	ffice		28f. Location (City or To	Street and No wn, State)	umber or Ru	ral Route Number,
	Hospite 4 hours Funere	edicai C	29a. Certifier 1 (A) Certifying Physi (Check only 2 Medical Examina one)	cian: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at restigation, in	the time, date my opinion, d	and place, a	and due to the ed at the time,	cause(s) and date and pla	manner as ce, and due	stated, to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				icense numbe			29d. Date sig		
1) OSY In			Z	3899	58		11/47	101	
			30. Name and addr-ss of person who con	pleted cause of death (Ite	т 23а) (Туре,	Print)	- 5/	3		1101	- 0	
W.	6		Da feet Single 31, Date file (Month, Day, Year)	32/Registrar's Sign	208 C	rain 1	yig hwa	y S	w ali	n Bu1	nie.	MS 21061

State Registrar

Date the Month, Day, Year)
NOV 28 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 💍 1 - For State Registrar Certificate of Death 2. Date of Death Month ent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 26,20010 Vovembe /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deast Examiner de (In vrs. last birthday Date of Birth (Month, Day, 6. Sex **Funeral** Days 1□M 2**X**F Director the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "netural", or iteme 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Household Name (First, Middle, Last) Be ဂ 19a. Informant's Name/Relationship (Type, Print) lhompson important: If item any injury or other 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens ess of Facility 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, should be referred to the cause on each line. Between and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cete has t certificete 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Tes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar and address of person who com

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

32. Regi

			For State Ragistrar	State	of Marylan			t of He e of D		d Mer		iemje eg. No.	006	40109
e,			1. Decedent's Name (First, Middle, Las	t)							Date of Deat Month	th Day	Year	3. Time of Death
	Physicia /Medic		Gladys Brown	na	Glenn						Sovembe		5 200	6 2:44 AM
	Examin		4a. Facility Name (If not institution, give	street and n					Location of E	Death			County of Dea	th
			Chester River	Ma	nor			este		20			Kent	
	Funeral		5. Social Security Number 6. S 236-01-3706	9X □M 2521F	7. Age (In yrs. 89		If Under Months	Days	If Under 24 Hours	Min	Date of Birth (Month, Day, 04/10/	Year)	9. Bir	thplace (State or Foreign ountry) WV
<u></u>	Director		Usual Residence of Decedent		0.	, ,,,,,				U	4/10/.	191/		w v
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary -1.eh	ţ	MD KENT		CH	ESTERI	OWN							1 ☐ Yes 2√☐ No
	r 28a	irec	10e. Street and Number				10f. Zip	Code			1		zen of What C	ountry?
	h witi 23a o	Funeral Director	414 BELL AVE.					21620)				USA	
	deat	ner	11. Marital Status	12. Was De Armed	cedent Ever in U. Forces?	.S. 13.	Was Dece f Yes, spe	dent of His	spanic Origin n, Mexican, P	? (Specify Puerto Rica	Yes or No- an, etc.)		14. Race - Am Black, Whi	
2	or it		1 Never Married 2 Married	1 ☐ Yes If Yes, C	s 2 ∏No Give X		1 🗆 Yes	2 X No	Specify:				Specify:	WHITE
Ś	be filed within 72 hours after death with the Maryland tal tygene. Its Hygene other then "naturel", or iteme 23a or 28a-f ehow dother then "naturel", or iteme 23a or 28a-f ehow event, I'm Madical Examinar must be invitted at	d by	3 XWidowed 4 ☐ Divorced	Year or	Dates:	16a. Dece	tent's lisu	al Occupa	tion		- 1	16b. Ki	nd of Business	/Industry
5	n 72	Completed	15. Decedent's Ec (Specify only highest gra	de completed		(Give	kind of wo	ork done di ise retired)	urina most oi	f working		100.11		
7	withi ene then	mo	Elementary/Secondary (0-12)	College	(1-4or 5+) 5+	TI	EACHE	R					EDUCAT	ION
2	Hyg other	Be C	17. Father's Name (First, Middle, Last)						18. Mother's	Name (F	irst, Middle,	Maiden	Sumame)	
g	lenta lenta rked ric ev	To B	EDWARD P. LEE						JOSE:	PHINE	HUDNA	ALL		
2	should and Men marke numatic	-	19a. Informant's Name/Relationship (-									r Town, State,	Zip Code)
Ξ	and 2 salth a n 27 ie		GORDON BROWNING/S	SON		1			, CHE		OWN, I			-
9	of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from	m State	Place of Dispo cemetery, crea	natory or	other place		Date			cation - City or	
	Pages ment of lant: if it		4 ☐ Donation 5 ☐ Other (Specif	v)	CHI	ESAPEA				1/16/	2006	STEV	ENSVIL	LE, MD
Baitimo	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, it a Madical Examinar must be notified at once.		21. Signature of Funeral Service Licer	2/1	fela	FI	ELLOW	S. HI	s of Facility ELFENB ROAD,	EIN A	ND NE	WNAM	I FUNER D 2162	AL HOME, PA
	1		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications tha	t eadsed the deat	h. Do not eni	er the mo	de of dying	g, such as ca	rdiac or re	spiratory arr	est,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	A	teriors	elevo	Stic	. (TI DR.	an la	n dr	ser	12	Onset and Death
	/Medical		resulting in death)	a. Due t	to (or as a consec	uence of):				200-	, , , ,	<u> </u>		1
	Examiner		Sequentially list conditions.	b										(
-	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	to (or as a consec	uence of):								
	ecute and trans	Examiner	that initiated events resulting in death) Last	c	to (or as a consec	uence of):	<u> </u>							
Ď,	certificate be executed nding physicien and use as the burial-transit	a E			(
28/60	phys phys s the	dicai		d										
×	that the death certification of the attending properties as	Physician/Me	tF FEMALE: 23b. Was decedent pregnant		outcome of pregn								23d. Date of de	elivery
ž	death	clar	in the past 12 months?	4□Pre	e birth 2 🗆 Feta agnant at time of c		⊒Ectopic p ⊒ Other (s						Month	Day Year
j.	the c by the ached	hysi	9 Unknown	9□ Un	known									
7	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions	contributing to	death but not res	sulting in the t	inderlying	cause give	en in Part I.		23e. Did to	bacco		to the cause of death?
ĕ	quire an sig	edt	Dementin-	1712	neim	e/ 7	YP	e		-	1 🗆 Y	es 2	No 3∏F	Probably 4 Unknown
Kecord	aw re	Completed					LY				24a. Was a		prior to	autopsy findings available completion of cause of
	The law te has b	E									autop perior 1 Yes	med?	death?	
Vital		Be C	25. Was case referred to medical						26. Place o	of Death (C	Check only o	пе)		
	Physician: this certific ral director,	P O	examiner? 1 Yes 2 No	Hospital:	☐ Inpatient 2☐	ER/Outpatie	nt 3 🗆 🖸		Nurs				6 □Other (Sp	ecify)
n of	ng Ph fter th ineral	1	27. Manner of Death Natural 5 Pending	28a. Da (M	ite of Injury Ionth, Day Year)	28b. Time o		28c. Injun Work			d. Describe h	iow inju	ry occurred	
20	endii eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not to				М		Yes 2 □ No		Laureign (6	24	of Missohan and	Over I Courte Alivertee
Division	or Att	Certification	4 Homicide determined	209. Pk	ace of Injury - At h litding, etc. (Speci	iome, farm, st fy)	reet, facto	ry, office		281	City or Tou	vn, State	a)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After the completely filled in by the funeral	edical C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To miner: On the	the best of my kn e basis of examin	owledge, dea ation and/or ir	th occurre	d at the tin	ne, date and pinion, death	place, and	d due to the d	cause(s) and manner a d place, and du	as stated. ue to the cause(s)
	the H in 24 the F	ledi	one)	and m	anner stated.									nth, Day, Year)
	To To	Σ	29b. Signature and title of certifier	1.			2	9c. Licens	at o	02		// .	I C _ A	1
1	8		6000	enj	cim n	20		111	010	U		11	1.20	Ю
			30. Name and address of person who	1	ause of death (Ite	m 23a) (Type	, Print)	he	2 ter	tow	n n	11	211	20
10	C.	ate	31. Date filed (Month, Day, Yeas) 1	17 2002	2. Regis ar's Sign	ature	1				_')	1.00		·
	Donfo	arte.	MUAT	1 4000	- DE BERRE	15.	1	all I						

			For State Registrar	State of Ma	aryland				ealth a D <i>eath</i>	nd Me		iene g. No.	006	40110	
	Dhualai		1. Decedent's Name (First, Middle, Last)								Date of Deat Month		Year	3. Time of Death	_
	Physicia /Medic			odges							Novembe				1
	Examin	A.,	4a. Facility Name (If not institution, give Heartland of Adel]	hi			Ade	1phi	Location of					eorge's	
tel	Funeral Director		242-14-3916	V	e (In yrs. Ia 32	Yrs.	Months Months	r 1 Year Days	If Under 2 Hours		. Date of Birth (Month, Day, ec. 29,	923	C	thplace (State or Foreig ountry) th Carolina	
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County D • C •		,	Town or Lo								10d. Inside City Limits 1 Yes 2 No	
	or 28	Dire	10e. Street and Number					Code			1	-	en of What C	-	
	e 23a	rai	1714 Irvin Stree	I N.W.	Ever in 11 9	12.1		010	Ispania Oria	sin2 (Speci	ify Yes or No-		ted Sta		_
0000	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-f show sumatic event, it a Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 21 If Yes, Give Year or Dates:			f Yes, spe	cify Cuba	Specify:	, Puerto Ri	can, etc.)		Black, White Specify: B.	te, etc.	
D-C 7	thin 72 ho e. an *natur Medicel	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		i+)	life. i	kind of w DO NOT i	ial Occupa ork done d ise retired	durina most	of working			d of Business	Andustry	
7	ygien ygien t, th	Con		2		Nu	ırse		10 Marks	de Name /	First, Middle, I		ical		
Jalla	ould be fit Mental H arked ott attic even	To Be	17. Father's Name (First, Middle, Last) Leslie Atkinson						Saral	h (U	nknown)			
Mar	ges 1 and 2 should t of Heath and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (T) Fannie J. Concrad)	19b. Mailir 215 F	ng Addres Emers	s (Street a	and Numbe treet	Apt	Route Number 103 NW	Wa:	Town, State, shingt	on, DC	
ע	Pages 1 and 3 nent of Health int: if Item 27 iry or other tra		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	CG	ace of Dispo emetery, crer t Linc	natory or	other plac	tery	Da 12/2/			twood,		
Dallillor	permit. Pages Department of the Important: if Ite any injury or of once.		21. Signature of Funeral Service Licens	Mel	le	22	2. Name a	nd Addres	ss of Facility	y Fort	Linco d Bre				
38	hysician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Atheros	clero	tic He				cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death years	
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	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Chronic	Kidn	ey Dis	sease	! 							_
8/00,	icate be executed physician and s the burial-transit	dical Ex	resoluting in death, East	Due to (or as	a consequ	ience or):									_
O. BOX o	ath certiff attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3[□Ectopic □ Other (s	oregnancy specify)	,			2	3d. Date of de Month	olivery Day Year	
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C)	elay has	Completed									24a. Was a autops perform		prior to death?		0
Vital	iclen: Th certificete ector, pag	ပိ	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes Check only or		1 🗆 Y 8	s 2□ No	-
	Physiclen: rthis certific ral director.	0 8	examiner?	Hospital:	ent 2 🗆	ER/Outpatier	nt 3 🗆 🛭	OA Oth			e 5∐ Reside		☐Other (Sp.	ecify)	
lon of	Jing After fune	ation: T	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry ly Year)	28b. Time o Injury	f M	28c. Injur Wor 1 🗌	yat k? Yes 2 ∐ I		3d. Describe h	ow injury	occurred		
Division	a # in =	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, el	ury - At ho c. (Specify	ome, farm, st	reet, facto	ry, office		28	Bf. Location (S. City or Town			Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral i completely filled	edicai (29a. Certifier (Check only one) 1 Medical Exam	rsician: To the best iner: On the basis of and manner st	f examinat	wledge, deat tion and/or in	h occurre ivestigatio	d at the tir n, in my o	me, date an pinion, dea	d place, ar th occurred	nd due to the c d at the time, c	ause(s) ate and	and manner a place, and du	as stated. ue to the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier	l.Bin	us I a	NO	2	9c. Licens					signed (Mor 9/2006	oth, Day, Year)	
2	4)		30. Name and address of person tho Anthony D. Bivins	.M.D. 1	06 Ir	ving	stre	et S	uite	418 N	W Was	hing	ton, D	C 20010	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signa	ture	1								Ī

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege

			1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artment of Hi rtificate of L		ental Hygie	2000	40111
	9		1. Decedent's Name (First, Midd	lie, Last)				2. Date of Death		3. Time of Death
	Physici /Medio		FLORA L. HOV	√E				Month NOVEMBER 27	Day Year 2006	4:40 A M
	Examin		4a. Facility Name (If not institution	on, give street and number		4b. City, Town, or			4c. County of Death	
				NURSING HOME			KVILLE		MONTGOMER	<u>'Y</u> _
	Funeral Director		5. Social Security Number 579-14-2742	6. Sex 7. Ag	ge (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye JANUARY 17,	9. Birthp Cour 1912 MAR	place (State or Foreign htry) XYLAND
	and *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or Lo	cation			1	0d. Inside City Limits
	daryli f sho	ō		CGOMERY					'	1 ☐ Yes 2X No
	the 2	Director	10e. Street and Number	GOTEKI	SIL	VER SPRING		100	Citizen of What Cour	
	3a or		3429 SOUTH	LEISURE WORLD E	T.VD		0906	109.		
	deatl	Funeral	11. Marital Status	12. Was Decedent		Was Decedent of His f Yes, specify Cubar		cify Yes or No-	U.S.A. 14. Race - Americ	can Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland piene. Ir then "naturel", or Items 23a or 28a-f show The Medical Examiliar out the modified at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes Give	No t	r Yes, specify Cubar 1 □ Yes 2 ② No	Specify:	Hican, etc.)	Black, White, Specify: WH	etc. ITE
2-0	72 ho	ted	15. Deceder	nt's Education est grade completed)	16a. Deced	dent's Usual Occupa kind of work done do	tion	16b	. Kind of Business/Inc	
2	within 7 ene. than *r	Completed	Elementary/Secondary (0-12)	College (1-4or	life. I	DO NOT use retired)	uring most of workir	ng		
12	illed w Hygier othar th		11	(CLERK/STENO			IRCRAFT COMP.	ANY
anc	d d d o	Be	17. Father's Name (First, Middle,				18. Mother's Name	(First, Middle, Maid	den Sumame)	
Ž	should be nd Menta s markad umatic av	P	CHARLES LAIRD 19a. Informant's Name/Relation:		19h Mailie	Address (Street a		DAUGHTERY	ty or Town, State, Zip	(C-1-)
Z	2 8 8 9		WAYNE SHEPPE - N							•
ē,	s 1 and 2 f Health itam 27 i		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	Di	ate 20c	ARYLAND 2090 Location - City or To	wn, State
E	Pages nent of int: If it iry or o		1 ☐ Burial 2 🖾 Cremation 1 ☐ Donation 5 ☐ Other (5		FT. LINCOLN	natory`or other place	12/1/2	006 PDE	NELIOOD MADE	7.4375
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service		22	. Name and Address	of Facility		NTWOOD, MARY	
			23a. Part1. Enter the disease, o	r complications that cause	the death. Do not ent	L800 NEW HAM or the mode of dving	IPSHIRE AVEN	VUE, SILVER	SPRING, MARY	YLAND 20904 Approximate
	Physician		Immediate Cause (Final	t only one cause on each li	ne.					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	OINY	reve	-		
	Examiner		Conventinity link conditions	, Cox	igestive	Hea	IT FO	- · lux		
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	consequence of):		i			
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	0					
60,	tificate be executed g physician and as the burial-transit		Total III a data () Educ	Due to (or as	a consequence of):					
68760,	physics the	edical		d						
	certif nding use a	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of delive	ny.
.O. Box	res that the death certigned by the attendin be detached for use	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 4□Pregnant a 9□Unknown		Ectopic pregnancy Other (specify)				Day Year
Δ.	that the ed by detac		Part II. Other significant conditi	ons contributing to death b	ut not resulting in the ur	iderlying cause giver	n in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Vital Records,	The law requires ite has been sign bage 2 should be	ted by						1 ☐ Yes		ably 4 ∐Unknown
3ec	e law has b	Completed						24a. Was an autopsy performed	prior to con	osy findings available inpletion of cause of
al	10 1		05.14					1 Yes 2		2 No
Ĕ	Physicien: this certific	o Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital:	all ED/O:	Other	26. Place of Death			
of	y Phys	-	27. Manner of Death	28a. Date of Inju	ry 28b. Time of	28c. Injury	at 28	e 5 Residence 8d. Describe how in	6 ☐Other (Specify)
ion	Attanding In death.	atlo	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, Da igation	y Year) Injury	Work?	es 2 No			
Division	l or Attano after death Director: I in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of Inj	ury - At home, farm, stre c. (Specify)	eet, factory, office	28	8f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis o	examination and/or inv	occurred at the time	, date and place, ar nion, death occurred	nd due to the cause	o(s) and manner as sta	ated. the cause(s)
	ithin (o tha	Mec	29b. Signature and title of contifie	and manner sta	atod.	29c. License	number	29d. [Date signed (Month, L	Day, Year)
	15 - 8		1 SFIS	xyyach	MO		62433		11 771	2001
	,-		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type. I				111011	
	Con		SAYED ELST 31. Date filed (Month, Day, Year)	194AD 97	15 Medi	(Cent	2 D. K	ockville	e,MD	20856
	Sta Registr		NOV 3 0	2006	J. J. And	de				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 04:00 M Janice Harrison Nov. 30 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner of Maryland Baltimore University If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
MAR 8 1940 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 ☐ M 2 🛂 F MARYLAND 66 Director 214-36-6186 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1XYes 2 □ No Funeral Director ST. MICHAELS TALBOT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21663 USA 317 SEYMOUR AVE. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGENT REAL ESTATE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RUSSELL C. HALL SARAH MCQUAY ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JERRY K. HARRISON/HUSBAND 317 SEYMOUR AVE. ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 12/2/2006 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601

Approximate 21. Signature of Funeral Service Licensee MERCERO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarc **Physician** /Medical Due to for as a consequence of) Examiner I bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ artic stenosis 3 Probably 2 🗌 No 1 Tyes 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director; 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Lombard Jump

State Registrar 31. Date filed (Month, Day, Year)

30

NOV

2006

32. Registrar's Signature

Drawin 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Irene B. Hamilton 2006 1:15/Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing Rehabi. Kent Cnt Chestertown Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** Days 1□ M X□ F 93 Yrs. Director 220-16-9471 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or items 23a or 28a-f ehov treumatic event, the Mudical Examerations the molified at MD Kent 1 ☐ Yes X ☐ No Director Chestertown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21620 9030 Fairlee Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Maryland 21215-0036 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 8th Factory Worker Vita Foods Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filment of Health and Mental Hant: If item 27 is marked oth jury or other treumatic even Be Dola Jones Eugene Brown P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9075 Fairlee Rd Chestertown, MD 21620 Solistine Briscoe-In Law Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Janes U.M. 11/25/06 Chestertown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kenneth Walley Funeral (W00026) Service 821 W. St. Annapolis, MD Part1. Effer the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) CARDIO PULLIONAN **Physician** /Medical Due to (or as a consequence of): Examiner Tue to (or as a consequence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit Anternal Desence The death certificate be executed enplual Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached f o. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, ementia 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 2 No of Vital Physician: ector, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖥 No Medical Certification; To this funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending 1 □ Yes 2 □ No i hours after death. uneref Director: A sly filled in by the fu death. investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff To the Funeref Di completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2388 completed cause of de th (Item 23a) (Type, Print) 223 1/254 Street, CHEStentown Hd21620 ARRIGAL TIL 31. Date filed (Month, Day, Year) 32. Regitrar's Signature State NOV 2 Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland (860 art 2) 15 96 Harth and Mental Hygiene (1) 1 - For Stata Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year ROBERT ANDREW HEIER NOVEMBER 18,2006 10:44P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14205 MEADOW CREEK LANE WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**XM 2□ F 59 Yre Director 213-46-5063 MAR.12,1947 WASH., D.C. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2X No Directo MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other than "naturel", or Items 23a or vent, the Medical Examiner must be 14205 MEADOW CREEK LANE 20601 U.S.A. Peges 1 and 2 should be filed within 72 hours after death and Mental Hygiene.
ant: if team 27 is marked other than 'naturel', or Items 23.
ury or other treumatic event, in a Medical Emeritan must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 CIVIL ENGINEER BEN DYER ASSOCIATES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS ANDREW HEIER HELEN FRANCES EDELEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN B. HEIER-SPOUSE 14205 MEADOW CREEK LANE, WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of Important: If It eny injury or o 1XXSurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST MARY'S CH. CEM. 11-27-06 BRYANTOWN MARYLAND 21. Signature of Furjeral Service Licensee Name and Address of Facility MO-0479 RAYMOND FUNÉRAL SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastaho renal cell carcinom /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Striknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2500 1 ☐ Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident the within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei completely (Check only one) ţ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62288 12006 30. Name and address of person while completed cause of death (Item 23a) (Type, Print) Da 31. Date file North, Pay, Year DUb 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4b per doc 2862 12-14-06 vt. State of Maryland / Department of Health and Mental Hygiene

For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year BETTY RUTH HESS 6:40 P M December 2006 /Medical 4b. City, Town, or Location of Path esville 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3045 Whiteford Road Whiteford Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/1/1935 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√□ F Director 71 Yrs Maryland 218-32-6951 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits the Medical Examinar must be notified a Harford 1 ☐ Yes 2 No Pylesville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3045 Whiteford Road 238 21160 USA permit. Pages 1 end 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!, or itema 23a any injury or other traumatic event, tra Medical Examinat minal page. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Line Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kermit John Bonham Bessie Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry C. Hess/Husband 3045 Whiteford Road, Whiteford, MD 21160 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Slate Ridge Cemetery 12/7/2006 Delta, PA 21. Si vature of Funeral Service Licent 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 17314 Part 1. Enter the disease, or comprications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** Fibresis ulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualth (bras a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2☐Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2/20No 4□Pregnant at time of death Month Day Year signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ś certificete has been si rector, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No Division of Vital 1 ☐ Yes To the Hospitel or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death | Check only one) examiner Hospital: 1 | Inpatient To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day Year) After t Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Uneck only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sind a wall 34208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIND A-WALSH 37/8 Num v/e less arrest suife 31. Date filed (Mooth Day, Year) 32 Registrar's Signature State

Registrar

				ental Hygiene Reg. Nor. 0 6 4 0 1 6 2. Date of Death 3. Time of Death
Physic /Med Exam	ical	4a. Facility Name (If not institution, give street and number) The Johns Hapkins Hospital	4b. City, Town, or Location of Death	Month Day Year November 30 2006 23:47 PM 4c. County of Death
Funera Director		5. Social Security Number 220-38-4203 Usual Residence of Decedent 1 PK 1/5 Hospital 6. Sex 1 M 24 F 65	Months Days Hours Min.	9. Birthplace (State or Foreign Country) ptember 25,1941 Maryland
the Maryland 28a-f ehow	rector	10a. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits 1 □ Yes 2 No
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinan must be notified at angles.	by Funeral Director	10e. Street and Number 11582 Norray Ci 11. Marital Status 1 □ Never Married 2 ☑ Married 11. Marital Status 11. Was Decedent Ever in U.S. Armed Forces? 11. Wese 2 ☑ Norray Ci 11. Yes 2 ☑ Norray Ci 12. Was Decedent Ever in U.S. Armed Forces? 11. Yes 2 ☑ Norray Ci	13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri	fly Yes or Nocan, etc.) 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: white
21215-0036 ad within 72 hours aff giene. er than "natural", or than Medical Exami	Completed b	3 Widowed 4 Divorced Year or Dates: 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Ho	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) memaker	16h Kind of Business/Industry
Maryland nd 2 should be files lith and Mental Hyg 27 Is marked othe rtaumatic event,	To Be C	William Austin Morrison, Sr.	Margaret	First, Middle, Maiden Sumame) Lois Brown
NOFE, ME Iges 1 and 2 s It of Heelth an If item 27 Is or other traus		Thomas Johnson - husband 1 20a. Method of Disposition 20b. Place cemet 1 ▼Burial 2 □ Cremation 3 □ Removal from State	b. Mailing Address (Street and Number or Rural 1582 Horray Circle, Ij of Disposition (Name of ery, crematory or other place)	amsville, Maryland 21754 20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of Hee Important: If them any injury or othe		21. Significe of Funeral Service Ligensee	2 1621 Opossumtown Pik	auffer Funeral Home e, Frederick, Maryland 21702
by OO', ate be executed hysicien and hysicien and the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the	oid Loukenia oon:	Approximate Interval Between Onset and Death 24 hours
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death	h 3 □Ectopic pregnancy 5 □ Other (<i>specify</i>)	23d. Date of delivery Month Day Year
law requires that the as been signed by the 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown
The The sage	Be Completed	25. Was case referred to medical	26, Place of Death (t	24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25c. No 25c
Hospital or Attending Physician: The law requires the hours after death. Funeral Director: After this certificate has been signed they filled in by the funeral director, page 2 should be of	Certification; To B	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	utpatient 3 DOA Cther: 4 Nursing Home	5 ☐ Residence 6 ☐Other (Specify) 1. Describe how injury occurred
pital or Att burs after d eral Direct filled in by t		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, f. building, etc. (Specify) 29a. Certifier		Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	29c. License number	at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
19		Michael R. Centle, Medical D 30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	November 30, 2006 fe Street, Baltimore, Maryland 21287
St: Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 4 2006 32. Registrar's Signature	Apple	tre sheet, paltimore, Maryland

06-09275 Rayanne Joseph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	, c	Certificate of	Death	Re	eg. No.			
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year								
	4a. Facility Name (if not instituted Shady Grove Adventi			b. City, Town, or Location Rockville	on of Death	4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 220–75–8079	6. Sex 7. Age (In y	rs last birthday) Yrs	If Under 1 Year If U Months Days Ho 3 26	th(MM/DD/YYYY) 9. Birth Foreign Cou				
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene ritem 27 is marked other than "natural", or items 23a or 28a-f show any r traumatic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	10e. Street and Number 19472 Brassie P. 11. Marital Status 1 X Never Married 2 M 3 Widowed 4 Di 15. Decedent's Education (Spe	Lace 12. Was Decedent Ever in Armed Forces? 1 Yes 2 X Norced If Yes, Give Year or Dates: 2019 only highest grade completed.	If Y If Y If A	10f. Zip Code 20886	Origin? (Specify Yes or Nocan, Puerto Rican, etc.)	Og Citizen of What Coun USA 14. Race - Americ White, etc SpecifyBlack	an Indian, Black,		
21215-0036 uld be filed within 72 hourn Mental Hygiene marked other than "natu t event, the Medical Exan o Be Completed	Elementary/Secondary (0-12) O 17. Father's Name (First, Middle		Never V	Vorked 18.Mot	ther's Name (First, Middle, N neika Tamara Bara				
MD 21219 12 should be filth and Mental P. 127 is marked unatic event.	Raynald Joseph 19a. Informant's Name/Relation Ameika T. Barnes	/ Mother	19472 F	Address (Street and I	Number or Rural Route Num	nber, City or Town, State,			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "matural", injury or other traumatic event, the Medical Examiner To Be Completed by I	20a Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service	n 3 Removal from State	cob. Place of Dispos crematory or oth Gate of Heav	ition (Name of cemetery ner place) ven Cemetery	Date December 11, 2006 PMS Funeral Home vd, W, Silver S	Silver Spring Inc.	, Maryland		
Physician /Medical Examiner		Cuddon amounto	eath. Do not enter the	ne mode of dying, such a	as cardiac or respiratory arro		Approximate Interval Between Onset and Death		
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequen c. Due to (or as a consequen							
execuran and and and and and and and and and a	X UNPENDED	d	F parMF of	265 3/12/∩7 T	T				
Dox 68760, the death certificate be- op the attending physicic ched for use as the burit. Physician/Medi	IF FEMALE: 23b Was decedent pregnant in past 12 months? 1 Yes 2 ✓ No 9 Ur	23c. If yes, outcome of	pregnancy 2 Fe	tal death 3 Ect		23d. Date of delivery Month D	ay Year		
ords, P.O. Box 68 w requires that the death certif us been signed by the attending should be detached for use as		tions contributing to death but a	not resulting in the u	ınderlying cause given ıı	1 Yes		ably 4 Unknown opsy findings available		
Reco	25 Was case referred to medic examiner?	111		I Othor	1 Yes	rmed? death? 2 No 1 Ye	ompletion of cause of		
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director, edical Certification: To Be (1 Yes 2 No	28a. Date of Injury (Month, Day, Year) Fnd 12/5/2000		njury 28c. Injury at V) pm 1 Yes 2	Vork? 28d. Describe	Residence 6 Other how injury occurred			
O File bo	(Check only 1 Certifying I	ermined (Specify) Found Physician: To the best of my known	at home		or Town, S Gaithersbi		Ave. Apt 104		
To the IIC within 24 To the Fur completely	one) 2 Medical Ex 29b. Signature and title of certif	aminer: On the basis of examination and manner stated lier	ion and/or investiga	29c. License num O.C.M.E.		29d. Date signed (Mor December 6, 200	th, Day, Year)		
	30. Name and address of person Theodore M. King, Ji	ATT.	cal Examiner	111 Penn Street,	Baltimore, MD 2120	1			
State Registra	State 31 Date filed (Month Dav Year) 2006 Registrar's Signature								

		partment of Health and ertificate of Death	Reg	ene 006	40118
Physician /Medical	CHALLES D ROBETHIAN		2. Date of Death November	29, 2006	3. Time of Death 2:00 p/ M
Examiner	A PP TATA AN PRE LA LANGUE A L	4b. City, Town, or Location of Dear Frederick	th	4c. County of Death Frederic	
Funeral Director	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday 146-20-9180 77 Yrs.	Months Days Hours Min		ear) Cou	place (State or Foreign ntry) Connecticut
e Maryland	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland Frederick Frederic				10d. Inside City Limits 1★ Yes 2 No
with the Ma a or 28a-1 to oximin		10f. Zip Code		. Citizen of What Cou	ntry?
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland of other than "neturel", or items 23a or 28a-f ehow event, Ira Madical Examination mail to multiple at Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Tes. Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify:	etc. White
should be filed within 72 hound be filed within 72 hound do Mentally Hygiene. To Be Completed To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 Sale 17. Father's Name (First, Middle, Last)	s Clerk	(F) A 6: 44	Men's clo	thing
should be fit of Mental H of Marked oth umatic even			me <i>(First, Middl</i> e, <i>Ma.</i> a lechman	iden Sumame)	
ad 2 street	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Ro 07 Faulkner Drive			
mit. Pages 1 ar pertment of Hea portant: if Item y Injury or othe	20a. Method of Disposition 20b. Place of Di	osition (Name of amatory or other place)	Date 200	ings Mill,	own, State
permit. Page Depertment of Important: If eny Injury or once.	21. Sign of re of Funeral Servi 3/4 icensee	22. Name and Address of Facility Since 621 Opossumtown Property 1	tauffer Fu	neral Home	
ficate be executed polysicien and sthe burial-transit edical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
certification of the second of		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
	Part II. Other significant conditions contributing to death but not resulting in the CHIPERTENSION, HYPERCIPIOEM	underlying cause given in Part I.	23e. Did tobace	co use contribute to th	/
1: The law requires that the death licete has been signed by the atter, page 2 should be detached for L Completed by Physiciar	MELLITUS, ATRIAL FIBRILLAS INSUFFICIENCY, PARKINSON	70N, RENAL	24a. Was an autopsy performed	death?	psy findings available inpletion of cause of
To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification; To Be Compl	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation (Month, Day Year) 28b. Time of Injury (Month, Day Year)	nt 3□ DOA Other: 4□ Nursing H	th Check only one ome 5 Aesidence 28d. Describe how in	e 6 □Other (Specify njury occurred)
ital or Att	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, Si	,	
thin 24 hour thin 24 hour the Funer impletely fill	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Cross one) 2 Medical Examiner. On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
To th withir To th comp	29b. Signature and title of certifier Mo	29c. License number 8 21 9 3 6		Date signed (Month, L	
0	30. Name and address of person who completed cause of death (Item 23a) (Type, A. Do NELSON 65C THOMAS				
State Registrar	31. Date filed (Month, Day, Year) DEC 0 4 2006 32. Peristrar's Signaturer				

		1 For State	State of M	1arylan		tment of F ficate of		d Mental H	20	206	1.0119
	-	Registrar 1. Decedent's Name (First, Middle,	Last)		Certi	iicale oi	Deam	2. Date of D	Reg. No.	JUb	3. Time of Death
Physic		Virginia Rita	· ·					Month	Day	Year 2006	1 1410
/Medi Exami		4a. Facility Name (If not institution,		r)	4	b. City, Town, o	or Location of D			nty of Death	
		Doctors Commun	ity Hospita	1		Lanha	m		Prin	ice Ge	orge's
Funeral		'	6. Sex 7. A	ige (In yrs. I	N.	If Under 1 Year Months Days		Hrs. 8. Date of E		9. Birth	place (State or Foreign intry)
Director		073-09-4668	1 M 2 LAF 9)1	Yrs.	Dayo	7,0010		8, 1915	. 1	ew York
and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion					10d. Inside City Limits
Mary -f sho	Ö	Maryland Princ	e George's		reenbel	_					1 X Yes 2 □ No
n the Maryland r 28a-f show notified at	irec	10e. Street and Number	e deorge s			10f. Zip Code			10g. Citizen	of What Cou	intry?
eath with ns 23a or must be i	a D	4-D Hillside	Road			2077	0			USA	
.0036 hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S		s Decedent of H	lispanic Origin	? (Specify Yes or Nuerto Rican, etc.)	lo- 14. F	Race - Americ	
36 safte		1 Never Married 2 Marrie	d 1 ☐ Yes 2 🕱	No		Yes 25 No	Specify:	acrio i licari, etc.)		Black, White, c <i>if</i> , Whit e	
15-0036 72 hours after dea "natural", or items adical Examiner m	Completed by	3 ₩ Widowed 4 □ Divorced	Year or Dates:			-					
in 72 in 72 ledic	olete	15. Decedent's (Specify only highest	grade completed)		(Give kin	t's Usual Occup d of work done o NOT use retired	during most of	working	16b. Kind of	Business/In	ndustry
212 I with giene.	E	Elementary/Secondary (0-12)	College (1-4or	5+)		maker	-/		Oram	Home	
Maryland 21215-0036 nd 2 should be filed within 72 hours affulth and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	BeC	17. Father's Name (First, Middle, L	ast)		1101110	ancı	18. Mother's	Name (First, Middi			
/lar	TO B	Maurice Simons					Eliza	beth She	ehan		
lar) 2 sho and lis ma	Г	19a. Informant's Name/Relationshi						r Rural Route Num			
re, Marand 2 Health 6 Health 6 tem 27 is		Karen K. Smith	/ Daughter					, Bethes	da, Mar	yland	20816
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 Burial 2 ☐ Cremation	3 □Removal from State	20b. Pi	ace of Disposition	on (Name of ory or other plac	ce) D	ec. 1,	20c. Location	n - City or To	own, State
timen trmen rtmen rtant:		4 Donation 5 Other (Sp.	ecify)		e of He		1 "				ng, Marylan
Bal permi Depar Impor any fr		21. Signature of Funeral Service L	censee					ns Funer			
		23a Part1 Enter the disease of a	amplications that cause	d the death						Sprin	ng, MD 2090
200	y 1,	23a. Part1. Enter the disease, of a shock, or heart failure. List o Immediate Cause (Final						ulac or respiratory	arrest,	10	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Car	dioje	TILE Shac	K				011	
Examiner			Acu	t M	ence of):	e infax	otima				
PETER.	Jer	Sequentially list conditions, if any, leading to intrinsidate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	s a consequ	ence of ye	9	o despite				
icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
ficate be exe physician a sthe burial-	ñ	resulting in death) Last	Due to (or as	s a consequ	ence of):						
icate be physicial s the buri	edical	•	d								
		IF FEMALE:	23c. If yes, outcome	e of pregnar	nev						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant a	2 🗆 Fetal	death 3 □Ec	topic pregnancy ther <i>(specify)</i>	/			Date of delive Month	ery Day Year
the cay the	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
res that the de signed by the a be detached f	by P	Part II. Other significant condition	s contributing to death t	but not resul	lting in the unde	rlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to th	he cause of death?
w require been sig should b						-		_ 1□	Yes 2□ No	3 ☐ Prob	oably 4 Unknown
law re as be 2 sho	Completed							24a. Wa	s an 24b	. Were auto	psy findings available mpletion of cause of
The ate h	le l							per	opsy formed? 2 No	death?	
sician: The law scertificate has b irector, page 2 s	Be (25. Was case referred to medical exampler?					26. Place of I	Death (Check only			20.00
Physician: The law requires tribis certificate has been signeral director, page 2 should be e	၉	1 ☑Yes 2 ☐ No			R/Outpatient		4 L Nursin	g Horne 5□Res	idence 6 □O	ther (Specif	y)
ing Affe une	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occi	urred	
or Attending after death. Director: After	Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	the t	lun. At hon			Yes 2 □ No	001.1	(0)		
lor A after o Direct	ertif	4 ☐ Homicide determin	28e. Place of in building, e	tc. (Specify)	ne, iarm, street,	ractory, office		28f. Location City or To	(Street and Nun own, State)	nber or Rura	al Route Number,
ospital hours uneral		29a. Certifier 1 Certifying	Physician: To the best	of my know	/ledge, death oc	curred at the tin	ne, date and pl	ace, and due to the	cause(s) and r	manner as e	tated
To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the	Medical	(Check only 2 ☐ Medicaf E. one)	xaminer: On the basis of and manner st	of examinati	on and/or invest	tigation, in my o	pinion, death o	ccurred at the time	e, date and place	and due to	the cause(s)
To the Hi within 24 To the Fi complete	Me	29b. Signature and title of certifier				29c. License			29d. Date sign	ned (Month,	Day, Year)
15		M. Dom	li, M	1		MDD -	2093.	3	11/28	106	
,-		30. Name and address of person w	ho completed cause of c	death (Item :	23a) (Type, Prin	it)		,	, , ,		
			NSKI M.D.	8100	60001	ver Ro	AD, h	ANHAM,	40 20	7040	
Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0	2006 32 Registr	rar's Signati	ure Angel	29					
negisti	ui	MON 9 A	LUUU FILLE	1 55	100000						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 2, 2006 **Physician** JENNY LUCILLE LEEDY 7:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2▼F Months Hours Min 88 Director 184-12-2954 APRIL 12, 1918 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Examinar notative notified at 1 ☐ Yes 2 No Directo MARYLAND QUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 PRINCESS ANNE DRIVE 21620 death v UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Ita ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** MENS CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ HARRY D. SPANGLER LOTTIE C. BAER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN THOMAS/DAUGHTER 229 PRINCESS ANNE DRIVE, CHESTERTOWN, MD 21620 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 12/04/2006 CHESTER, MARYLAND permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Immediate Cause (Final Physician of the disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under Jung Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 99 1 Yes 2 No 3₽Probably 4 Unknown Completed Deed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? 1 Yes 2500 or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Certification: To uneral dir this 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 🗌 Yes 2 \square No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and til e of c 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIVP () () wash 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2006 Registrar DEC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 22, 200 Month Lanovette **Physician** Margart 9:40P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Westminster NVSING Wastminst (mall) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/03/1910 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F Months Days Hours 96 Washington, DC Director 216-74-9730 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examinar must be conflict at 1 Yes 2 No Director Maryland Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ 3X Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Maker Own Home rmit. Pages 1 and 2 should be filed w spartment of Health and Mental Hygier portant: If Item 27 is marked other they Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theodore W. Alexander Margaret Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore Lanouette/ Son 5 Pennington Drive Westminster, MD 21157 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 11/27/2006 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician emento e w /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical ettending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown 9 Unknown ģ peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed: certificate 1 ☐ Yes 2 ☐ No 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

anc.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registra & Signature

29c. License number

100059943

29d. Date signed (Month, Day, Year)

24,2000

November

			For State	Type or P State of		d / Dep		of He	ealth a		-	/giene		40122	
			Registrar 1. Decedent's Name (First, Middle, La	st)		00	lineate	OI L	, catir		2. Date of D		o Xeer	3. Time of Death	
Nr.	Physici /Medio		Homer Robert Lynd				# 02 T-			Death	Novemb		, 2006	6:30A. M	
all	Examir	er	4a. Facility Name (If not institution, given 9924 Snowy Hill T	errace		fant himbalan	4b. City, Too Laure	el	If Under 2		9 Date of B		Howard	place (State or Foreign	
	Funeral Director		5. Social Security Number 262-28-3768 Usual Residence of Decedent	M 2□F	. Age (In yrs.			Days	Hours	Min.	8. Date of B (Month June15	,1919	919 Alabama		
	Aaryland Febow	or	10a. State 10b. County Maryland Howard			y, Town or Lo urel	ocation							10d. Inside City Limits 1 ☐ Yes 2X No	
	with the h	Direct	10e. Street and Number 9924 Snowy Hill	Terrace			10f. Zip Co	723					on of What Cou		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow sup injury or other traumatic event, the Medical Examiner must be notified at Ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Zives 2	es? ! □ No		Was Deceden If Yes, specify	Cubar	spanic Orig i, Mexican, Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)		4. Race - Ameri Black, White Specify:		
Maryland 21215-0036	within 72 hou iene. rthen "nature the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation		(Give	dent's Usual C kind of work of DO NOT use i	done di	tion uring most	of worki	ng		d of Business/Ir	ndustry	
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Many	eith and P	•	19a. Informant's Name/Relationship (Theresa A. Lynd -	Type, Print) Wife		19b. Maili 9924	ng Address (S Snowy I	Hil.	l Ter:	or Rura	l Route Num Laure	e ^{r, City} or Ma	ry Land	20723	
Baltimore,	Pages 1 and nent of He sent: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		1 0	emetery cre	nsition (Name matory or othe ns Ceme	r niace	ry 1) 2006		ation - City or T $nsville$	own, State e, Maryland	
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60,	ate be executed //Medical Examiner transit he burial-transit	lical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or	ch line.	uence of): CB uence of):	PAC	50	UL	AF	RA	CCI	SENT 15	Approximate Interval Between Onset and Death	
O. Box 687	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fete nt at time of d	I death 3[Ectopic pregr Other (speci					23	d. Date of delive	ery Day Year	
rds, P.	pures that i n signed by uld be deta	ρ	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying caus	se give	n in Part I.			tobacco us		the cause of death?	
Division of Vital Records, P.O.	The law rec	Completed								_	24a. Wa auto per 1 🗆 Yes	s an opsy omed? 2 X No	24b. Were auto prior to ⇔ death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No	
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	マイ / comple	Me	29b. Signature and title of certifier	M	~ir			icense 53 1 4	number +5				signed (Month, nber 27		
	[,,,		30. Name and address of person who Arvind Desai, M.	completed cause D. 115 Ro	of death (Item Desler	n 23a) (Type Road	Print) Glen Bu	ırni	ie, Ma	ary1	and 21	060			

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Registrar

31. Date filed (Month, Day, Year) NOV 3 0

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Physician
/Medical
Examiner

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1. Decedent's Name	e (First, Middle,	Last)							Date of De Month	eath Da	av	Year	3. Time o	of Death	
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er	4a. Facility Name (If	not institution,	give street and number)			4b. City,	Town, or	Location of	of Death		40	. County	of Death			
	Washing	eton Co	unty Hospita	a1			Hag	erst	own			Wa	shir	oton		
	5. Social Security N	umber	6. Sex 7. Ag 1 ☐ M 2 💢 F	e (In yrs. last bir.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th a <i>y, Year</i>		9. Birth	place (<i>State</i> ntry)	or Foreign	
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by [3 ☐ Widowed		ed 1 □ Yes 2 ½ If Yes, Give Year or Dates:		1	1 ☐ Yes ¾☐ No Specify: SpecifyWhj							Whit	e		
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	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hatchers Cemetery 12-6-06 20c. Location - City or Total Company of the place of Disposition (Name of cemetery, crematory or other place) 12-6-06 Wears Vall															
	21. Signature of F	fieral Service L	icensee	T.	22.	Name an	nd Addres	s of Facili	ty Dot	ıglas A	. Fi	ery	Fune	neral Home		
	1	anul	O- Paulay	,JR,	13	31 E	aste	rn Bl	Lvd.	Й. Hag	erst	own	Mary	land 2	21742	
	23a. Part1. Enter t shock, or hea	he disease, or and failure. List of	complications that cause only one cause on each I	d the death. Do i ine.	not ente	r the mod	le of dyin	g, such as	cardiac	or respiratory a	arrest,			Approxima Interval Be	etween	
	Immediate Cause ((Final	aut	2 181	20	V	100	W	0					Onset and	AXC	
	resulting in death)		Due to (or as	a consequence	of):		1							-	15	
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Be Completed by Physician/Medical Examiner			d	(3 10	~~		W)	9,								
/Me	IF FEMALE:	at prognant	23c. If yes, outcome									23d. Da	ate of deliv	verv		
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y Pł	Part II. Other signi	ficant conditio	ns contributing to death	out not resulting i	n the un	derlying c	ause give	en in Part		23e. Did	tobacco	use con	tribute to	the cause of	death?	
q p	Emy	spyc	ema							1₹	Yes	2□ No	3☐ Pro	obably 4]Unknown	
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Ö	25. Was case refer	rred to medical					960	26. Plac	e of Deat	th (Check only	\rightarrow		103	2010		
TO B	examiner? 1 ☐ Yes 2 ☑	OA Oth	er: 4□N	ursing Ho	ome 5□Res	idence	6 □Oth	ner (Spec	ify)							
2	27. Manner of Dear		Time of Injury	2	28c. Injur Worl	y at k?		28d. Describe	how inj	ury occur	rred					
atio	1;⊠Natural 2 ☐ Accident	5 ☐ Pending investig	М		Yes 2□	No										
tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	nod Zoe. Flace of it	jury - At home, fa tc. <i>(Specify)</i>	arm, stre	et, factor	y, office			28f. Location City or To			ber or Ru	ral Route Nu	mber,	
Medical Certification:																
cal	29a. Certifier (Check only		g Physician: To the bes Examiner: On the basis	of examination a											(s)	
ledi	one)	d title of an att	and manner s	tated.		20.	c Licens	e number			20d D	ato ciara	od (Month	ı, Day, Year)		
2	29b. Signature and	une of certifier	.0			290	C. LICETIS	~ / ' ^	1-0	<u> </u>	172	- F = A	N PEI	3.2	2006	
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	30. Name and add	ress of person	who completed cause of	death (Item 23a)	(Type, F	Print)	Angel .	Par	ti it	expital	11	GEA	cotra	W 1. "	TZW	
	TILLIC	HICKNIC	110-TZ/100	trar's Signature	(Ju)	nin,	JUL	M	11.X H	others	111	rok	2100	UNI C	1.110	

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State Registrar

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aMEND iTEMS 25,29 tata of Manuland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 11, 2006 **Physician** 14:00 PM CHARLES GRINDEL LEIGHT /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MILLINGTON KENT 32936 SPEER ROAD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year) 09/30/1923 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 110 M 2□ F 83 Yrs. 212-20-3590 MD Director Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at MILLINGTON 1 Yes 2 No MD KENT Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 32936 SPEER ROAD 21651 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or has any injury or other trainment. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 3 Widowed 4 □ Divorced 2 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PURCHASING AGENT **MEDICAL** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CLIFTON R. LEIGHT FLORENCE LUKEN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL ALEXANDER/DAUGHTER 32936 SPEER ROAD, MILLINGTON, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 11/13/2006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 21. Signature of Funeral Service Licenses 130 SPEÉR ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner MEDICAL EXAMINER mentia the attending physician end hed for use as the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, CERTIFICATIONAPP Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient to Yes 20€No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ٩ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 5 Pending investigation Subject fell 1 ☐ Yes 2 No efter death. Director: Af 09/23/06 Unknown ^M 2X Accident 3 Suicide 6 Could not be determined To the Hospital or Attal within 24 hours effer der To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 32936 Speer Rd., Millington, MD Home Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHhew King MD 30; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 7 2006 Registrar

Michael Charles Laird

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 10125

iichael chanes La	1-	For State Of Waryland / Department of Fleath and Wich	ia. r ij gion	Reg. I	ZUU0 No.	40125
Physician/	1.	Decedent's Name (First, Middle,Last)		of Death th Da ember 17	ay Year	3 Time of Death 0430 hrs
Nedical Examiner		Michael Charles Laird, Sr. a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location		ember 17	7, 2006 4c. County of Deat	
		400 Phillips Avenue Cambridge			Dorchester	
Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last birthday) 16-70-5099 1 M 2 F 46 Yrs. If Under 1 Year I	er 24Hrs. 8. Dat Min. Feb		Corni	rthplace (State or gn puntry) New York
'n		sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location				10d Inside City Limits
daryland 28a-f show any datonce.	M	aryland Dorchester Cambridge				1 Yes 2 No
the Maryland a or 28a-f sh tiffed at once	1	De. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	
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er death with , or items 23 r must be no	1	1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican			White, etc.	Ican Indian, Black,
after de al", or ner mi		Widowed 4 Divorced If Yes, Give Year or Dates			Specify:	White
hours in maturi		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give during most of working life. DO NOT	kind of work don use retired)	ne 16	6b. Kind of Business	/Industry
5-0036 red within 72 hours afti vygene. other than "natural" the Medical Examine Completed by		11 Parts S	alesman		Tractor	
		Charles Edward Laird	r's Name (First, M			
1 2121. Ould be filed Mental Is s marked tite event,		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nur	Alice Fa			e, Zip Code)
MD 7		Jessica Hitch/Daughter 2904 Schooner Wa	y, Cambi	ridge,	, MD 2161	_3
re, l s l and of Healt of Healt of Healt		0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	2	0c. Location - City o	r Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If itel	4	DorchesterMemorialPar	k 11/21/	/200 6	Cambridge	e, MD
Ball permit Depar Impor	5	1 Signature of Funeral Service Licensee 22. Name and Address of Facility Curran—Bromwell 308 High St.,	l Funera Cambrida	al Hon	ne, P.A. 21613	
Physician	2	3a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.	cardiac or respira	atory arrest,	, shock, or heart	Approximate Interval Between Onset and
/M i I Examiner		mmediate Cause (Final disease a <u>Cocaine intoxication</u>				Death
	1	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
iner		f any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
60, ate be executed nysician and e burial - transit	LYB G	Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d				
be exection and initial - t		X UNPENDED #1,23a,27,28a-f, perME, g862 12/	27/06 TT_			
8760, ifficate be us physic is the bur		F FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 1 1 ive hirth 2	ic pregnancy		23d. Date of delive Month	ry Day Year
ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - transition of the physician Affection and the physician	331518	past 12 months? 4 Pregnant at time of 5 Other (Specify) 1 Yes 2 No 9 Unknown				
O. E nat the or deby the etached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F				o the cause of death?
Division of Vital Records, P.O. ra or Attending Physician: The law requires that the an effect of the this certificate has been signed by led in by the funeral director, page 2 should be detach			— L	ta. Was an		autopsy findings available
(ecords, he law require: ate has been signage 2 should be				autopsy performe	prior to ed? death?	
n: The tificate or, page	ر ا د	25. Was case referred to medical 26.Place of Death			N 1 V	res 2 No
Vital sysicians this certi		examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4	Nursing Home		esidence 6 🗸 Oth	er: Scene
		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Wo (Month, Day, Year) 28b. Time of Injury 28c. Injury at Wo	_	escribe hov	w injury occurred	
Sion		2 Accident Fnd 11/17/2006 Fnd 4:25 am 28e Place of Injury - At home, farm, street, factory, office building,	יאחוו ו	NOWN ocation (Str	eet and Number or F	Rural Route Number, City of Phillips Ave
Division of Division of Optial or Attending Photos after death Tilled in by the funeral Director: After the Control of the Con	Certification	Suicide 6 X Could not be determined (Specify) found on sidewalk	Cami	rown, Stat bridge	te) 400 blk. MD	of Phillips Ave
5 H = 2	<u>.</u>	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and property one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and due to occurred at the tir	the cause(me, date an	s) and manner as stand place, and due to	arted the cause(s)
4 8 4 8	¥ -	29b. Signature and title of certifier 29c. License number	er	1	29d. Date signed (M	
		Theodore M. King TR., Mis, O.C.M.E.			November 17, 2	2000
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, B	altimore, MD	21201		
Star Registra	te	31. Date (Month, Day, Year) 32. Registrar's Signature				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician November 17, 2006 6:25 P. M Mary Kathryn Little /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Oakland Garrett Garrett Co. Memorial Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Yrs. 1917 West Virginia July 19, **Director** 235-40-1790 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 'natural', or Itams 23e or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic awant. It is Medical Examinar must be notified at 1 Yes 2 No Director WV Tucker Parsons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26287 USA 112 Elkins Street Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Dept. Store (Retail) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millie Ethel Cross William A. Kelley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14800 Potomac St., Cumberland, MD Virginia Kelley/sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Parsons, WV Parsons City Cem. Nov 20, 2006 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., PO Box 275 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heard failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Vascular Accident 2 weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest and the cause). Due to (or as a consequence of) Examiner be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by Gastrointestinal Bleeding 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Emphysema this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding P After 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: , 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Hospital

State Registrar

Medicel Exam

ne and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

29h

(Check or

Signature and title

31. Date filed (Month, Day, Year)

Medical



🛮 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

D0023979

er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

11/27/2006

		1	For State Registrar	State of Maryland			t of He e of D		R	eg. No.	16	40127
	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of Deal Month	Day	Year	3. Time of Death
	/Medic	al	Mary M. McCoy						Decembe		006	8:30 A ^M
7	Examin	er	4a. Facility Name (If not institution, give st Calvert Manor Heal			,,	ising	ocation of Death		4c. County		
			5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthdav)	If Under		If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Funeral Director		212-70-0013	M 2X F 97	Yrs.	Months	Days	Hours Min.	June 27	7,1909 Maryland		
			Usual Residence of Decedent						Juile 27	J 1 7 0 7		
	how		10a. State 10b. County	10c. City,	Town or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma	cto	Maryland Cecil	R	ising							
	ith th	Director	10e. Street and Number			10f. Zip			1	0g. Citizen of		
	s 23a		1881 Telegraph R	oad 2. Was Decedent Ever in U.S	12 1		1911	panic Origin? (Sp	acity Yes or No-	United	SZAZ e - Americ	
36	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Joal Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes, Give Year or Dates:		Yes, spec		panic Origin? (Spi , Mexican, Puerto Specify:	Rican, etc.)	Blad	ck, White, o	etc.
Maryland 21215-0036	2 hou		15. Decedent's Educ	ation	16a. Deced	lent's Usua	al Occupat	ion		16b. Kind of B	usiness/înc	dustry
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ם	be filed tat Hygir d other event, I	Be (17. Father's Name (First, Middle, Last)	0			1	18. Mother's Name		Maiden Suman	ne)	
₹		은	Howard Mendenhal		405 14-15-		/Chunh na	Nora Y		City or Town	State 7in	Code
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Typ									
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Lowell W. McCoy/so 20a. Method of Disposition	20b. Pla	I J I ace of Dispo metery, cren	sition (Nai	me of	e. Risin		20c. Location		
Ď			1 ØBurial 2 ØCremation 3 □Re '4 □Donation 5 □Other (Specify)	moval from State	metery, cren Dokvie				_2006 1	Disimo	Sun.	Maryland
Baltimore,	permit. Page Depertment of Important: If any injury or	1	21. Signature of Eureral S	15/10	22	. Name ar	nd Address	of Facility R.T	- Foard	Funera	l Hom	P.A.
8	permit. Departr Importa any inju		1					n St., R				, , , , , , ,
			23a Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the death.	Do not ent	er the mod	de of dying	such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Pnysician		Immediate Cause (Final	Divertica							ć	Onset and Death
	/Medical		disease or Indition resulting in death)	Due to (or as a conseque								47
	Examiner	L	Sequentially list conditions, b									
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or):							
	cate be executed physician and the burial-transit	хаш	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):							
8760,	be e	<u>e</u>										
687		edical										
Box	death certific e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan		JEctopic p	regnancy				te of delive	
	0 0 2	icia	in the past 12 months? 1 ☐ Yes 2 PNo	4 Pregnant at time of de		Other (s				Mo	onth	Day Year
P.0	that the deed by the detached	hys	9 ☐ Unknown									4.1-11-0
	es gu	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the u	nderlying (cause givei	n in Part I.	23e. Did to	-		ne cause of death?
Records,	w requir	Completed	Demening							(*		
ec	e law has b	nple							24a. Was a autop perfor	sy	were auto prior to co death?	psy findings available mpletion of cause of
al F									1 🗆 Yes	2 No	1 🗌 Yes	2 No
Vital	Physician: The larthis certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	ospital:			Othe	26. Place of Deat	th <i>Check onli oi</i> ome 5 ☐ Resid		(0:	
of	4 = E	1: To	1 Yes 2 No	1 Unpatient 2 U t	R/Outpatier 28b. Time o		28c. Injury	at	28d. Describe h			γ)
on	iding Phi th. : After thi s funeral	tlor	1 Valural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work¹ 1 ☐ Y	? es 2 □ No				
Division	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, sti	reet, factor	ry, office		28f. Location (S City or Tow		ber or Rura	l Route Number,
ā	s after sal Direct	Certification:	4 Homoldo	ballding, etc. (Specify,					2.7	/		
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my knowner: On the basis of examination and manner stated.	vledge, deat ion and/or in	h occurred vestigation	at the time n, in my op	e, date and place, inion, death occur	and due to the dired at the time, d	ause(s) and m date and place,	anner as s and due to	tated. o the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29	c. License	number		29d. Date signe	ed (Month,	Day, Year)
			1 Noul Ex			1	700	58351	1	12/10	0	
	9		30. Name and address of person who co	0 0	23а) (Туре,	Print)		0.11	Neil E	1 41	14	. ^
	1			Day Pising	YHM	1 MI	160	411	Noil F	Latte	V 140	ıμ,
• =	St Regist	ate	31. Date filed (Month, Day, Year)	32, negistrar's Signat	do	wells						

DHMH 17 Rev 1/2001

State Registrar (CHO

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Year oral VCLL November 29 2000 03:51AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopleine. HOSPI -174 JOHKS Timeize 8. Date of Firth (Month, Pay, Year)
Aug. 10, 1920 Pennsylvania If Under 24 Hrs. 5. Social Security Number 7. Age (In rs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F Min 182-16-3931 86 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than "natural," or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Directo MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Stoney Lane 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Types 2 No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Architect Construction pormit. Pages 1 and 2 should be file Department of Health and Mental Hy Intportant: If item 27 is marked oth affy injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick F. Murray Agnes Walsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael K. Murray / P.O. Box 334 Mt. Storm, WV 26739 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/30/2006 Alexandria, VA. 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Ow Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 51 /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of) Examiner igned by the attending physician and be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has autopsy death? 2 X No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient ۵ 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MUBLE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore Maryland 21287 Victoria Mobley WO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

06-09316 Clark V Moiles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		l-For State Registrar				Certific		f D	Death				Reg N	0.			
Physicia Medical Exami	n/	1. Decedent's Name (First, Midd			ernon	Moiles					2	2. Date of De Month Decemb	Day	, Yea	г	3. Time of I 1813 h	
		4a. Facility Name (if not institution	n, give		umber)				City, Town, or Le	ocation of	Death			4c. County of Baltimor		ntv	
,		Franklin Square Hosp	6. Sex		7 400 (10	yrs. last b	idhday/		If Under 1 Year	If Under	24Hrs	8 Date of	Birth (MI	M/DD/YYYY			e or
Funeral Director	ŀ	5. Social Security Number 218–68–2579		M 2 F	7. Age (ii	50	Yr:	ı	Months Days	Hours	Min.	11/0			Foreig	n	MD
	t	Usual Residence of Decedent															
d how any		10a State 10b. County MD Ba	ltin	nore	100	c. City, Tow	n or Loca	ation	Esse	ex							City Limits
and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygene ten 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 327 Poplar Roa	 d					1	Of. Zip Code 2	1221			10g. C	itizen of Wh	at Cour	try?	
th with th ems 23a t be notii	Funeral D	11. Marital Status 1 Never Married 2 N		12. Was De Armed F		er in U.S.			Decedent of Hisp , specify Cuban,				No-	14. Race White		can Indian, I	Black,
	by Fur		orced	1 Yes If Yes, Give Ye or Dates:	2 X				es 2 X No				_	Specify:		White	
nours	ed L	15. Decedent's Education (Spe				ted) 16a	 Decede during n 	ent's most	Usual Occupation t of working life. I	on (Give ki DO NOT u	ind of wo se retire	ork done ed)	16b	. Kind of Bu	siness/I	ndustry	
036 ithin 721 me r than "1	Completed	Elementary/Secondary (0-12)		College (1-4 or 5+) 1			Т	ruck Dr		_				amst	ers	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	Be Col	17. Father's Name (First, Middle Clark V. Moi		Sr.					18	_		First, Middle		en Surname)		
MD 21; nd 2 should the salth and Mener an 27 is mar	2	19a. Informant's Name/Relation Clark Moiles				1		-	ddress (Street						n, State. 254 0		
and 2 and 2 fealth item 2	ı	20a Method of Disposition					e of Dispo	ositio	on (Name of cem			Date		c. Location -	City or	Town, State	
OOF ages l nt of i		1 Burial 2 X Cremation		Removal f	rom State		atory or o		matory		Dec	2. 9, 2006	1	Baltin	ore	, MD	
Baltimore, permit Pages I ar Department of Hee Important: If ite	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service		ee			²² B	Nan	ne and Address (of Facility Sons	5. P	.A. S	ever	na Pa	rk F	unera	1 Home
	4	23a. Part I. Enter the disease, o	H	160	1	dooth Do	4	95	Gov. R	itch:	ie H	wy, Se	ever	na Pa	rĸ,	MD 2	1146 ate Interval
Physician /Medical		failure. List only one cause	e on eac	ch line.						30011 30 03	i dido di	respiratory .	arroot, c	arioux, or rick		Between	Onset and eath
Examiner		Immediate Cause (Final diseas or condition resulting in death)		Heroin Oue to (or as			шиох	100	atton								
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		Oue to (or as	a consequ	ence of):										<u> </u>	
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last		Due to (or as	a consequ	ence of).					-						
760, ficate be executed g physician and s the burial - transit		X UNPENDED	¬¬ <u>x</u> -	AMENDED													
8760, tificate be on the physicial as the burial	n/Medical	IF FEMALE:	A	23c. If yes	#1,23e			per	rME, <u>e</u> 863.	1/10	/07 T	Τ	12	23d. Date of	delivery	_	
		23b. Was decedent pregnant in past 12 months?	the	1 Live	birth Inant at tim	e of death	_ =		death 3	Ectopic	pregnan	ісу		Month	[ay	Year
), Box 61 the death cert by the attendir	Physicia	1 Yes 2 No 9 U	nknown		nown	e or death	5 C	Othe	r (Specify)				1				
	by Ph	Part II, Other significant cond	tions	contributing	to death bu	ut not resul	ting in the	unc	derlying cause gi	ven in Par	rt I.		d tobaco	No. 3		the cause of	
IS, P quires 1 en sign	ted t											24a. W					gs available
COFC Law re has be	Completed											pe	topsy rformed	1?	death?	ompletion o	_
Re: The		25. Was case referred to medic	ai T						26.Place	of Death (Check o		s 2	No 1	✓ Ye	es 2	No
/ital	o Be	examiner?	_	ospital: 1	Inpatient	2 🗸 ER	/Outpatier	nt :		Othor:	1	Home 5	Res	idence 6	Other		
of \ng Phy		27. Manner of Death		28a. Dat	e of Injury th, Day,Year	28	b. Time of	f Inju			- 1	28d. Descril	oe how	injury occurr	ed		
ion trendin leath tor: /	atio		nding estigatio		2/6/20		d 5:2		om	es 2 X		unknow					
Division of Vital Records, P.O ra dra or Attending Physician: The law requires that the started red at the range of the range of the range of the range of the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Certification:	3 Suicide 6 X Co	uld not be ermined	oe		od at h		reet,	factory, office bu	uilding, etc		28f. Locatio or Towr	n (Stree n, State) VID	and Numb	oplar	ral Route N Road	umber, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funcal Director: After this certificate I completely filled in by the funeral director, page	Medical Co	29a. Certifier 1 Certifying	aminer:	an: To the be On the basis	est of my ki s of examin	nowledge,	death occ	urre gation	ed at the time, dat on, in my opinion,	te and pla death occ	ce, and	due to the c	ause(s)	and manner place, and c	as state	ed. e cause(s)	
To with	Me	29b Signature and title of certif		GITO THATTHE	Juney.				29c. License	number			29	d. Date sign	ed (Mo	nth, Day, Ye	ar)
		tate lever	vii	YE	ollal	hus			O.C.N	И.Е.			D	ecember	7, 200	06	
		30. Name and address of person Patricia Aronica-Poll				th (Item 23a dical Exa		1	111 Penn Str	eet, Ba	ltimore	e, MD 21:	201				9
S Regis	tate trar		112	32. F	Refistrar's	Signature		6	and s								
				Nº3	The state of the s	-	200	E val.	40.00								

Kenneth Howard Meadows

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 40131

	F	- For State Certificate of Death		g. No.	
Physician	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month November		3. Time of Death 1914 hrs
Medical Examin		Kenneth Howard Meadows 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		25, 2006 4c. County of Death	
(Prince George's Medical Center Cheverly		Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	n(MM/DD/YYYY) 9. Birt	
Director		577-80-4818 1X M 2 F 49 Yrs. Months Days Hours Min	04/03/	1957 Con	untry) New York
any	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	5	Maryland Anne Arundel Gambrills			1 Yes 2 X No
Maryli 28a-f	Jec C	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
th the 23a or notifie		1764 Thistle Court 21054		SA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	nue	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 X Yes 2 No		14. Race - Ameri White, etc.	can Indian, Black,
s after ral",	ğ.	3 Widowed 4 Divorced If Yes, Give Year 1 76—179 1 Yes 2 X No specify:		Specify: Whi	
2 hour "natu	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	tired)	16b. Kind of Business/I	ndustry
036 thin 7 ne.	Completed	2 Fleet Manager		US Capitol	Police
MD 21215-0036 d 2 should be filed within 7 life and Mental Hygiene. In 27 is marked other than aumatic event, the Medica		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	aiden Sumame)	-
121 Id be f fental narkee		Kenneth Meadows Marilyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Agnes T		Zin Codo)
AD 2 shou and M and M 27 is m	٢	Karen Kay Meadows/Wife 1764 Thistle Court G			, zip Code)
e, N I and I Health item	t	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
MOF Pages ent of nnt: If	ı	Maryland	30/2006	Crownsvill	e. MD
Baltimore, permit. Pages I a Department of He Important: If ite	ľ	No.	bert E.	Evans Fune	
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries			Between Onset and Death
- starriner		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate but (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
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760, cate be executed physician and the burial - transi	Medical	UNPENDED AMENDED			
8760, ifficate being physic is the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of delivery Month) Day Year
th certifications	sician	past 12 months? 4 Pregnant at time of 5 Other (Specify)			,
Box he death c	3	g Unknown	230 Did to	pacco use contribute to	the source of death?
n of Vital Records, P.O. Box 687 ding Physician: The law requires that the death certifi After this certificate has been signed by the attending funeral director, page 2 should be detached for use as the	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 No 3 Prob	
rds, requir	ompleted	**	24a. Was a autops		topsy findings available completion of cause of
eco he law ate has	g W		perform	ned? death?	
al Rian: T	앎	25. Was case referred to medical examiner?			
"Vit	E P	1 Yes 2 No Rospital 1 Inpatient 2 Y ER/Outpatient 3 DOA Oute 4 Nursi		Residence 6 Other	:
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Nov 25, 2006 28b. Time of Injury 1819 hrs 28c. Injury at Work? 1 Yes 2 ✓ No		ow injury occurred torcycle lost contro	ol and ejected
Divisior pital or Attenc ours after death teral Director: filled in by the	ifica	2 V Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Ru	
Dj spital nours a	8	4 Homicide determined (Specify) Major Road / Highway	1500 Block of I	ate) Defense Highway, G	ambrills, MD
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To t To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
		7.C. (1) 0.C.M.E.		November 26, 20	006
	+	30. Name and address of person who completed cause of death (Item 23a)			
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201		
Sta Registr	ate rar	31. Date filed (Month, 1997 Year) 9 200 32. Referrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** John Dillan Meagher 12:40 p /Medical November 27, 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgemery

9. Birthplace (State or Foreign Country) Manor Care-Silver Spring Silver Spring
If Under 1 Year 1 If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 577-32-6080 Director Washington, DC April 20, 1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 601 Cannon Road 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates 1943 – 45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Salesman Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Paul Meagher Helen Winifred Dillon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Theresa T. Meagher/ Wife 601 Cannon Road, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 28. Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 2006 21. Signatur of Funeral Service Licerises 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only energiates on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 24 Hours /Medical Due to (or as a consequence of): **Examiner** Pneumonia 1 Week Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Dementia 2 Years burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 □ No 3 Probably 4 Monknown 1 Yes director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4₺ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours arter death e Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10+1

State Registrar

DHMH 17 Rev 1/2001

d25085

100 Heorgia avenue, Selver &

November 27, 2006

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6

1 - Stata Registra Certificate of Death 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) **Physician** 2004 /Medical 4c. County of Death Facility Name (If not institution, give street and number, 4b. City. Tiown, or Location of Death Examiner RHOWK Hours Min. 8. Date of Birth (Month, Day, Year) 06/20/1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 92 213-22-6124 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, Ira Modical Examinational be notified at once. 1 ☐ Yes 2 X No Director QUEEN ANNE'S MILLINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3122 MILLINGTON ROAD 21651 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) NOAH MERCHANT MAE CAHALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3122 MILLINGTON ROAD, MILLINGTON, MD 21651 DONALD MARVEL/SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State ASBURY CEMETERY 12/03/2006 MILLINGTON, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, is along to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner ospitel or Attanding Physician: The law requires thet the death certificate be executed hours atter-death.

hours atter-death.

uneral biractor: After this certificate has been signed by the attending physicien and yi filled in by the funeral director, page 2 should be detached for use as the burial-transit yi filled in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the inpage 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 213 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral L Hospitel Seatifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29b. Signature and title certifier 29d. Date signed (Month, Day, Year) D51735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21620 HURCH HILL RID CHESTEDTOWN MD RELPSOY MO FREDERICK 6602 (31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 2006

		1	State of Maryland / Dep	artment of Health and M rtificate of Death	Mental Hygiene Reg. No.2 0 0 6	40134
	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 12/01/2006 Year	3. Time of Death 3:15 PM
	/Medic	al -	Wayne W. Parsons Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
	LXdiiiii		Atlantic General Hospital	Berlin If Under 1 Year If Under 24 Hrs.	Worcest 8. Date of Birth 9. Bi	
	Funeral Director		5. Social Security Number 6. Sex 1 A M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	Months Days Hours Min.	09/22/1953	rthplace (State or Foreign country)
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I.	ocation		10d. Inside City Limits
	a-faho	ctor	MD Worcester Bishopv	ille		1 ☐ Yes 2 🛣 No
	with the	Directo	100.077 Daniel and Number	10f. Zip Code 21813	10g. Citizen of What C	country?
	deeth	Funeral	10027 Peerless Road 11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "netural", or itema 23a or 28a-f show aumatic event, the Madical Exandrar must be notified at aumatic event.	by Fu	1 Never Married 2XXMarried 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2X No Specify:	Specify:Wh	
200	72 hou netural		45 Decedent's Education 163 Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	16b. Kind of Busines	s/Industry
121	within ene. than "	Completed	Flomostan/Secondary (0.12) College (1-4or 5+)	e Foreman	Construct	ion
Maryland 21215-0036	al Hygi d other	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumame)	
<u> </u>	hould b d Ment marked matic e	၉	Preston Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Irma Ha	ISTINGS ral Route Number, City or Town, State,	Zip Code)
Σ,	and 2 shalth an alth an 27 ferenteau		Mary D. Parsons (wife) 1002		shopville, MD 218	
Jore	ages 1 at of He : If Item		1) KBurial 2 ICremation 3 IRemoval from State 1	ematory`or other place)	Date 20c. Location - City of D4/2006 Libertytow	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic as <u>once</u> .				urbage Funeral Hom	
8	88 = 8		asa, Part1. Enter the disease, or complications that dauged the death. Do not e	<u> 108 William Street</u>	: Berlin, MD 21811	Approximate
	Physician		shock, or heart failure. List erriy one cause on each line.		FARCTION	Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	DCARDIAL INF	112077019	TEW PLS
		Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ecuted and transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed oblysicien and the burial-transit	calE	d			
9	ertificat ling phy e as th	Medi	IF FEMALE:		004 5-1-44	
S. Box	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physiclan/Medical		☐Ectopic pregnancy ☐ Other (specify)	23d. Date of d Month	Day Year
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ords	require een sig nould b					Probably 4 Minknown
of Vital Records,	e lav has je 2	Completed			autopsy prior to performed? death?	autopsy findings available completion of cause o
ita	iclen: Th certificete rector, pag	BeC	25. Was case referred to medicat examiner?		ath (Check only one)	23 22 110
	Phys this ral di	. To	Hospital: 1	of 28c. Injury at	lome 5 Residence 6 Other (Sp. 28d. Describe how injury occurred	pecify)
sion	Attending or death.	atlor	1 Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No		
Division	f or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or City or Town, State)	Hural Houle Number,
	To the Hospital or Atterviewithin 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause(s) and manner arred at the time, date and place, and d	as stated. ue to the cause(s)
	To the vithin to To the comple	Me	29b. Signature and title of certifier	29c. License number D 06244	29d. Date signed (Mo	
			Dorothy O. Holworth, Mid			
1	3A 5		30. Name and address of person who completed cause of death (Item 23a) (Type DSX 0-TH-Y & HOLZWOZTH	M.D. 203 SNOW	UST. SNOW HILL	MD. 21863
	St Regist	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type 15 of 14 of 1	fool		

Sally Ann Pirone Növember "26, 2006 12: When the state of the state o			1 - State Registrer	State of Maryland		rtment of H tificate of I			ene () () 6	40135
46. City, Town, or Location of Issain. 1204 Green Holly Drive Special Secure Number 1204 Green Holly Drive Special Secure Number 1204 Green Holly Drive Special Secure Number 1204 Green Holly Drive Special Secure Number 1204 Green Holly Drive Special Secure Number 1204 Green Holly Drive 1205 City, Town or Location 1206 City, Town or Location 1206 City, Town or Location 1207 Exercise 1208 Part States 1208 Pa				Ann		Pirone			- °26,200°€	3. Time of Death 12:05p M
Discretication Disc			1204 Green Holly I			Annapol:	is		Anne Ar	undel
100. Street and Number 100. Clay, Town or Location 100. Clay Town or Location 100. Clay Town 100.				M 2DE		If Under 1 Year Months Days	Hours Min.	(Month, Day, Y	9. Birth Cou	place (State or Foreign intry) PA.
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29b. Signature and title of certifier 29c. License number De 8118 29d. Date signed (Month, Day, Year)	To the within To the comple	Me	29b. Signature and title of certifier	Ahm do	~					
30. N e and address son who completed cause of death (Item 23ah (Type, Print) STANDY I. WATKINS IN 3UD BESTGASE NO PANNANU MO 2 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			STANLEY P.	WATRINS	Vn	Print) 900 B	EST GAT	eno re	armand	mo 2140/

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-09351 State of Maryland / Department of Health and Mental Hygiene Steven Palance Certificate of Death 1- For State Registrar Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 8, 2006 0037 hrs Medical Examiner Steven M. Palance 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville Shady Grove Adventist Hospital 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Director 10/17/1962 Country) NY 131-56-9974 1 XM 44 Usual Residence of Decedent 10d Inside City Limits Oc. City. Town or Location any 10a. State 10b. County Rockville 1 X Yes 2 No MD Montgomery 28a-f show notified at once. hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20850 United States 13001 Glen Mill Road or items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. White, etc. Armed Forces Never Married 2 X Married 2 X No White 1 Yes Divorced If Yes, Give Year Yes 2X No specify: Specify Widowed "natural", ģ or Dates 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed ges 1 and 2 should be filed within 72 ho it of Health and Mental Hygiene. : If item 27 is marked other thau "na other traumatic event, the Medical Ex College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 John Robert Powers **CFO** 5+18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Judith E. Eisenberg Arthur M. Palance Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other traumatic 13001 Glen Mill Road Rockville MD 20850 Dianna L. Palance - Wife 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place 1 X Burial 2 Cremation 3 Removal from State 12/10/06 Olney MD Department of Judean Memorial Grdns 4 Donation 5 Other Specify 22. Name and Address of Facility 1091 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Linux 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and requires that the death certificate be executed Physician/Medical YUNPENDED AMENDED attending physician for use as the burial -#23a,27,perME, g863, 1/5/07 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown a Unknown the a 23e Did tobacco use contribute to the cause of death? as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy this certificate has I director, page 2 s performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certifi 25. Was case referred to medical Be Other₄ examiner? Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 2 1 🗸 Yes 2 28a. Date of Injury (Month, Day,Year 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 No 5 Pending the 2 ___ Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License numbe December 8, 2006 OCME wi, mo 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

Registrar's Signature

BALLES

Assistant Medical Examiner

2006

State

Registrar

Ling Li, MD

31. Date filed (Month Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Pм **NOVEMBER 29** 2006 1:50 DENNIS ROBIEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CHESTER 1924 SHERMAN DR. If Under 1 Year Months Days 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1**X**M 2□F WASHINGTON D.C. 58 Director 218-54-7631 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County r 28a-f ahow 1 ☐ Yes 2 X No MD QUEEN ANNE'S CHESTER Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With rthen "natural", or iteme 23a or the Medical Examiner must be 21619 USA 1924 SHERMAN DRIVE Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after i Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAIL CARRIER U.S. POSTAL SERVICES 12 and Mental Hyginis marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GUSTAV ROBIEN MATILDA MUELLER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 1924 SHERMAN DRIVE, CHESTER, MD DEANNE ROBIEN / SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the important: if its eny injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 12/01/2006 STEVENSVILLE, MD 21666 21. Signature of Funeral Section License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart laiked. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelodysplatic **Physician** syndrone 76months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 3 ☐ Probably 4 ☑ Unknown Lymph idema 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Chroni autopsy performed 1 ☐ Yes 1 Yes 2 No 2 🗆 No or Attending Physician: 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Aftar th 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Matural 5 Pending s after decrei Atr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours af To the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001 REDVON

DEC

31. Date filed (Month, Day, Year)

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MD

32. Registrar's Signature

2108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #25.28f.Per ME PGC 11-30-06cm Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 15 2006 **Physician** Rosalie M. Reid /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Hospital Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthiffeen State of Fareign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🛣 F Yrs. 87 Sep. 6, 1919 Republic Director 578-22-5667 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10h County 10c. City, Town or Location 1 X Yes 2 □ No ns 23a or 28a-f sh must be notified Director Prince George's Upper Marlboro Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 United States 12812 Regrave Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No Dominican Baltimore, Maryland 21215-0036 Specify: Specify: Black-Spanish þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th D.C. Employee Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Thomas Valentine Hunt ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any injury or other trau
once. Emily Mitchell/Daughter 12812 Regrave Drive, Upper Marlboro, MD20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 11/20/2006 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 eldar 23a. Part1. Ehler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ician and burial-trans attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes - 25 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred foll at Natural 5 Pending investigation home November 15 1 ☐ Yes 2 ☐ No 2 Accident 2006 within 24 hours after death To the Funeral Director: 6 ☐ Could not be At ome, farm, street, factory, office 28e. Place of injury - At on building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 12812 Regrave Drive home LCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely c. License number 29d. Date signed (Month, Day Year ed cause of death (Item 23a) (Type, Print) 30. Name and whees of person who comple 75 Main Street, Suite 351, haurel, MD. 20707 31. Date filed (Month, Day, Year) NOV 3 0 2006 32. Registrar's Signature State Registrar

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The part of the pa	O. Box	y the attending ched for use a	ysician/M	23b. Was decedent pregnant in the past 12 months?					•					
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State 31. Date filed (Month, Day, Year) Registrar's Signature 1. Registrar's Signature 1. Registrar's Signature 1. Registrar's				DAWST M	come	20,0	u?	2 17/2	gond	phri	Mi	61	0912	
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Please Type or Print in Black Indelible Ink Maryland / Department of Health and Mental Hygiene

atrick Alan Rugg	1	For State eqistrar	•	ficate of			g. No. 20	06 40141		
Physiciar Medical Examin	1/ 1	Decedent's Name (First, Middle,Last) PATRICK ALAN RUGGLES				2. Date of Death Month November		3 Time of Death 1239 hrs		
		a Facility Name (if not institution, give street and number) Alt Rt 40 west of Cool Hollow Road		4	b. City, Town, or Location of Hagerstown		4c. County of Washingt			
Funeral			e (In yrs las	t birthday)	If Under 1 Year If Under		h(MM/DD/YYYY)	Birthplace (State or Foreign		
Director		111-70-8640 1X M 2 F	21	Yrs	Months Days Hours	FEB. 3		COUNTEW YORK		
, any		Da. State 10b County	10c. City, T	own or Location	on			10d Inside City Limits		
e Maryland or 28a-f show any fred at once.	힐	MARYLAND WASHINGTON 10e. Street and Number			BOONSB 10f. Zip Code		g Citizen of Wha	1 XYes 2 No		
th the Maryland 23a or 28a-f sho notified at once	Director	100 GROVE LANE			21713			U.S.A.		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene int. If item 27 is marked other than "natural", or items 23a or 28a-f should be transmatic event, the Medical Examiner must be notified at once or other transmatic event, the Medical Examiner must be notified at once	= 1	11. Marital Status 1 XNever Married 2 Married 12. Was Decedent Armed Forces? 1 Yes 2			Decedent of Hispanic Origins, specify Cuban, Mexican,		14. Race - White,			
s after d	اھ	Widowed 4 Divorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade companies.			Yes 2 No specify	kind of work done	Specify WHITE of work done 16b Kind of Business/Industry			
5-0036 led within 72 hours after Hygiene "natural"; other than "natural"; the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 8	use retired)							
15-003 filed within Hygiene d other th	Comp	12 17. Father's Name (First, Middle, Last)	's Name (First, Middle, M	laiden Surname)						
21215-0036 uld be filed within 7 Mental Hygiene marked other than	8	ARTHUR ELWOOD RUGGLES 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Street and Num	NA BARISHPO		ı, State, Zıp Code)		
e, MD 2 I and 2 shou Health and N item 27 is n		ARTHUR E. RUGGLES, FATHER		124 N	ORTHSHORE DR	IVE, ANDERS	SONVILLE.	, TN 37705		
nore, ages I an of Hea nt: If iteu other tra	1	20a Method of Disposition 1 Burial 2 XCremation 3 Removal from Sta	cre	ematory or oth	tion (Name of cemetery, er place) G CREMATORY	Date 12/01/2006		City or Town, State BURG, MARYLAND		
Baltimore, permit Pages I ar Department of Hec Important: If ite injury or other ir	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. N	ame and Address of Facility	7606 OT		NAL PIKE		
ம் கீக் ச ச	\dashv	231. Part Enler the disease, or complications that caused	the death. [ST FUNERAL H	OPE BOONS BO	DRO, MARY	YLAND 21/13		
/Medical Examiner		fail be as tonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a const						Death		
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	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Steade or injury that initiated								
cuted nd transit	Exa	events resulting in death) Last Due to (or as a cons	equence or)							
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED IF FEMALE: 23c, If yes, outcome and the second of the	me of pregn	ancy			23d Date of	delivery		
6876 certificat nding physes as the	ian/M	23b Was decedent pregnant in the past 12 months?	time of dea	2 Fet	tal death 3 Ectopioner (Specify)	c pregnancy	Month	Day Year		
Box 6876 To death certificate the attending plue for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	-	5 Ott		230 Did to	bacco use contrib	bute to the cause of death?		
P.O. es that the igned by oe detach	۾	Part II. Other significant conditions contributing to deat	n but not res	suiting in the u	ngenying cause given in Fa			Probably 4 Unknown		
ords, w requir s been s should I	Completed					24a Was a autop perfor	sy p	Vere autopsy findings available rior to completion of cause of eath?		
Rec		25. Was case referred to medical			26 Place of Death	1 🗸 Yes		Yes 2 No		
Vital hysiciau this cert	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie		ER/Outpatient			Residence 6			
Ing After		27 Manner of Death 1 Natural 5 Pending 28a. Date of Injuny (Month Day Nov 29, 2006)		28b. Time of I 1222 hrs	njury 28c. Injury at Worl	Driver auto a	now injury occurre auto collision			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	Suicide 6 Could not be			et, factory, office building, e	or Town, S	itate)	er or Rural Route Number, City ow Road, Hagerstown, MD		
Hospita 24 hours Funera		4 Homicide 29a Certifier 1 Certifying Physician: To the best of n	ny knowledg	e, death occur	red at the time, date and pl	ace, and due to the caus	e(s) and manner	as started		
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated 29b. Signature and title of certifier	mination an	d/or investigat	29c License number	courred at the time, date		ed (Month, Day, Year)		
		CarolHal	Doc	_	O.C.M.E.		November	30, 2006		
OH-10		30. Name and address of person who completed cause of Carol Allan, MD Assistant Medical Exa			Street, Baltimore, MD	21201	17.57			
St	ate	31. Date filed (Month, Day, Year) 32. Registro	ar's Signatur	e Mars	de		_			
Regist DHMH 17 Rev 1/20		MANUS & S. S. S. S. S. S. S. S. S. S. S. S. S.	and Paragram of the	ORIGINA						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER **Physician** LUTHER M. SCROGGINS 2006 6:00 AM /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BEL AIR
If Under 1 Year If Under 24 Hrs. HARFORD UPPER CHESAPEAKE MEDICAL CENTER 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 🕅 2□ F Months 422-16-0691 88 Yrs 30, ALABAMA Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County I show the Medical Examiner count be notified at 1 TYYes 2 ☐ No Directo ABERDEEN MARYLAND HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 1410 WILLSHIRE DRIVE 21001 USA Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1940–45 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US GOVERNMENT MAINTENANCE ENGINEER 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental is marked F. D. SCROGGINS ္က LELA WESTBROOK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) : If item 27 1410 WILLSHIRE DRIVE, ABERDEEN, MARYLAND 21001 isposition (Name of Date 20c. Location - City or Town, Stete WILLE R. SCROGGINS / WIFE Baltimore, 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 5 Burial 2 Cremation 3 Removal from State permit. Pag Department Important: I any injury o ST. JAMES UNITED CEM. 12/6/06 HAVRE DE GRACE, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, Dian Scott Coleman MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) Pulmonary Embolism 30 minutes Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Emphysema Completed Diabetes nellitus Type TI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Chronic Kedney Disease certificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After t 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death 2 Accident within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43115 11-30-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA Ave Harrede Grace, MD 5-Union 31. Date filed (Month, Day, Year)
DEC 0 4 2 State 0 4 2006 Registrar

		•	For State Registrar	,	State of Ma	ryland	Cert	rtment of ificate of	Death	Mentai i	Hygien Reg. N	1 C C	40142
.A.	Physicia /Medic		1. Decedent's Name (First, John Aug		Shepard					2. Date of Month	mber	29, 2006	3. Time of Death 5:50 A ^M
	Examin Funeral Director		4a. Facility Name (If not ins 1032 Wales 5. Social Security Number 261-78-723	Drive	reet and number)	(In yrs. 1a	ast birthday)	4b. City, Town, La P If Under 1 Year Months Days		h	4	c. County of Death Charles	olace (State or Foreign http:) Carolina
	ryland thow		Usual Residence of Deceder 10a. State 10b. C	County			, Town or Loc						10d. Inside City Limits 1 X Yes 2 □ No
	he Ma	Director		harles	3	L.	a Plat				10- 6	- / W# - / O	
	With t	Ö	10e. Street and Number 1032 Wales	Drive	۵			10f. Zip Code 20646	5			Citizen of What Cour J.S.A.	nuy?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "ratural", or Items 23a or 28a-f show important: if Item 27 is marked other then "ratural", or Items 23a or 28a-f show appring ry or other traumatic event, the Madical Examinar must be notified at appea.	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 Div	12 Marned	2. Was Decedent E Armed Forces? 1 Thes 2 No ff Yes, Give Year or Dates:		j		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes of to Rican, etc.		14. Race - Americ Black, White, Specify: Wh	etc.
Maryland 21215-0036	within 72 houene. then "nature	Completed	15. De (Specity onty Elementary/Secondary (0	cedent's Educa highest grade 0-12)	ation completed) College (1-4or 5+ 4	-)	(Give k life. D	ent's Usual Occu ind of work done O NOT use retire Comman	during most of word)	rking		Kind of Business/In	dustry
d 2	i Hygi Other	Be Co	17. Father's Name (First, M	fiddle, Last)	<u></u>			oomman.	18. Mother's Nar	me (First, Mic			
ylar	Menta Menta arked aric ev	To B	John S. Sh	epard					Heler	n M.	Mah	ler	
Jan	2 sho		19a. Informant's Name/Rei		· ·							or Town, State, Zip	
e,	Healt Healt tem 2		Anita M. S 20a. Method of Disposition			20b. Pl		Wales ition (Name of atory or other pla		Date		MD 2064 Location - City or To	
Baltimore,	it. Pages rtment of rtant: If I njury or o		t X Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot 21. Signature of Funegal Sc	ther (Specify)		0a	klawn	Cemet	ery 12/4		_	ksonvill	
Ba	permi Depa Impo eny ii		Danto	ich	chol De							Home MD 206	
	Physician /Medical		23a. Part1. Enter the diseashock, or heart failure Immediate Cause (Final disease or condition resulting in death)	ase, or complic a. List only one a.	Essp	hag	eal a	r the mode of dy	ng, such as cardiad	c or respirato	ry arrest,		Approximate Interval Between Onset and Death 4 moS
4	Examiner	_	Sequentially list conditions	, b.	Due to (or as a								
	outed d ansit	Examiner	Sequentially list conditions havy, bearing to introduce cause. Enter Underlying Cause (Disease or injury that initiated events	` 【。	Due to (or as a	CONSECU	ianica ot):						
68760,	ficate be executed physicien and is the burial-transit	edicai Exa	resulting in death) Last	d.	Due to (or as a	consequ	ience of):						
О. Вох	death certif e ettending id for use a:	Physician/Med	fF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	arit	c. ff yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal	death 3 1	Ectopic pregnand Other (s <i>pecify</i>)	Sy			23d. Date of delive Month	ery Day Year
ords, P.	The law requires that the de ste has been signed by the e bage 2 should be detached t	þ	Part fl. Other significant co	onditions cont	ributing to death bu	t not resu	ilting in the un	derlying cause g	ven in Part I.			o use contribute to the	he cause of death?
Vital Records,		Completed								a	Vas an utopsy performed?	prior to co death?	opsy findings available impletion of cause of 2 No
₹	Physician: r this certific ral director,	o Be	25. Was case referred to n examiner? 1 ☐ Yes 2 ★ No		ospital: 1 🖂 Inpatien	t 2 🗆 I	ER/Outpatient	3□ DOA O	26. Place of Dea			6 ☐Other (Specif	(v)
sion of	ding h. Afte fune	ertification; T	27. Manner of Death 1. Natural 5 2 Accident	Pending investigation	28a. Date of fnjung (Month, Day	,	28b. Time of Injury	28c. Inju				jury occurred	77
Division	al or Attens s after deatl al Director; ed in by the	Certific		Could not be determined	28e. Place of Injurbuilding, etc.			et, factory, office			on (Street Town, Sta	and Number or Rura ate)	al Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edicai (29a. Certifier 14 Ce (Check only 2 Me one)	ertifying Physi edical Examin	cian: The last of er: On the basis of and manner state	examinat	wledge, death ion and/or inv	occurred at the estigation, in my	me, date and plans opinion, death occu	and due to urred at the ti	the raunal me, date a	(n) and manner as n indiplace, and due to	ituled. o the cause(s)
)	To the H within 24 To the Fi complete	Me	29b. Signature and title of	ceremen	mel	Ro	SCHEWS	29c. Licer	se number			Date signed (Month,	
0	Bikel		30. Name and ress of p		npleted cause of de	ath (Item	23a) (Type, F	Print)	7) 1	0:20		evember >	Zec 4
7	Sta Registi		31. Date filed (Month, Day,	Ceinala EC 0 4	32. Registra 2006	r's Signal	WR5	house for	uc	2030			

	4	For State Registrar	State o	of Marylar		artment rtificate			Ment	al Hygien	2000	40143	
Physicia		1. Decedent's Name (First, Middle, Las		C					. M	ate of Death onth	30 2004	3. Time of Death 4:55 P M	
/Medic Examin		Effie Catl 4a. Facility Name (If not institution, give Manokin Man			omers	17	Town, or	Location of De			Some	١ .	
Funeral Director		5. Social Security Number 6. Security 193–18–8189	x □ M 2 XF	7. Age (In yrs. 90	last bîrthday) Yrs.	If Under Months		If Under 24 H Hours Mi	n. (M	ate of Birth fonth, Day, Yea -23-191	r) 9. Birti	nplace (State or Foreign untry) yland	
If I I I I I I I I I I I I I I I I I I	Il Director	Usual Residence of Decedent		Pr	ty. Town or Lo		Code	853			Citizen of What Co	10d. Inside City Limits 1	
ING X IX IS-UUSO be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "natural", or theme 23a or 28e-f show event. I've Medical Exural or mail be realified at	ted by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	edent Ever in U orces? 2 No ive Dates:	16a, Dece	1 ☐ Yes 2	tent of Hi city Cubai	spanic Origin? n, Mexican, Pue Specify:		es or No- , etc.)	14. Race - Ame Black, White Specify:	ite	
Mary land 4 14 13-0050 d 2 should be filed within 72 hours af th and Mental Hygiene. 7 le marked other then "natural; or treumatic event. I've Medical Exur.	Be Completed	(Specify only highest grades) Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)		(1-4or 5+)	life.	maker	e retired,			Ow t, Middle, Maide	n Home		
aryian should be and Mental e marked o umatic eve	To B	Frank Catlin 19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address	(Street a			e Revel te Number, City	or Town, State, Z	ip Code)	
Daltimore, Marylat permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 le marked any Injury or other treumatic engage.		Barbara Davis/Date 20a. Method of Disposition **Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from	State	PO Bo Place of Disponentery, cres echwoo	nsition (Nan	ne of ther place	·	MD 2 Date	20c.	Location - City or		
permit. F Departme Importar any Injur		2). Signature of Funeral Service Licen	see	M0029	Hi 5 11	nman 673 S	d Addres Fune omer	s of Facility ral Hom set Ave	ie P	rincess	incess Anne, M		
Physician /Medical Examiner	0	/ shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	(or as a consec	quence of):	gscvs avkn	40					Onset and Death	
Goath certificate be executed death certificate be executed e attending physician and defor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec	quence of):	40101	S 0 1						
. C. BOX OX of the death certifically the attending place of the action of the control of the co	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	1 🗀 Live	utcome of pregn birth 2 Feta mant at time of c nown	al death 3	Ectopic pro		621			23d. Date of deli Month	very Day Year	
T hat die total		Part II. Other significant conditions of	ontributing to	death but not res	sulting in the u	nderlying ca	ause give	in in Part I.	. 2		/	the cause of death?	
	Completed									4a. Was an autopsy performed?	prior to death?	topsy findings available ompletion of cause of	
g Physiclen: The graphs of this certificate had alrector, page	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o Injury		A Othe	at Nursing	Home 5		6 □Other (Speciary occurred	ify)	
To the Hospital or Attending Physicien: To the Hospital or Attending Physicien: To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	1 Alatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plac	e of Injury - At h	ome, farm, str	M reet, factory	1 🗆 '	res 2 □ No	28f. Le	ocation (Street lity or Town, Sta	and Number or Ru te)	ral Route Number,	
Hospital 24 hours a Funerel E	edical Ce	29a. Certifier 1 Certifying Ph (Check only one)	iner: On the	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim , in my or	e, date and pla pinion, death oc	ce, and di curred at	ue to the cause the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)	
To the within To the comple	Me	29b. Signature and title of certifier	W	/			b. License				id. Date signed (Month, Day, Year)		
		30. Name and address of person who		use of death (Ite	m 23a) (Type,	Print)	v s	5 5.	40151	30 24	2/1/06 MD 2/89	94	
Sta Registr		31. Date filed (Month, Day, Year) DEC 0 6 2	1	Registrar's Sign	41010								

11/30/2006 4:55pm

Effle Somers

			State of Maryla	and / Depa	artment of H	ealth and M	-	-	10111
			State Registrar	Cer	rtificate of L	Death		g. No. UUD	40144
1	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	27, 2006	3. Time of Death 1:45 A M
	/Medic	al	EMMA LOU SCHWALENBERG 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Nov.	,	
-	Examin	er	3100 PYLES DRIVE		Upper Ma			Prince Ge	orge's
	Funeral	255	1 TM 2 TM	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign
	Director		217-34-0788 71 Usual Residence of Decedent	Yrs.			06-19-19	935 Was	h.,DC
	yland Now			City, Town or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Maryland Prince George's	Jpper Ma	r1boro				1€ Yes 2 No
	vith th	Director	10e. Street and Number		10f. Zip Code	20	774	g. Citizen of What Co USA	ountry?
	eath v	Funeral	3100 Pyles Drive 11. Marital Status 12. Was Decedent Ever in	U.S. 13.1	Was Decedent of Hi			14. Race - Ame	nican Indian,
9	after d	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.
003	72 hours after death with the Maryland Insturat', or Iteme 23e or 28e-f ehow Ideal Exactions from the rediffical at	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:						hite
15-(n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work f)	ing 1	6b. Kind of Business/	Industry
212	filed within Hygiene. ther than "	omo	Elementary/Secondary (0-12) College (1-4or 5+)		Homema		(Own Home	
pu	be filed within 72 hours after death with the Marylan Ital Hygtiene. Id other than "natural", or Iteme 23a or 28a-1 show event, it a Madical Examinar must be indiffed at	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumame)	
yla		2	Lewis Seltzer	10, 11, 2	111 (8)		Finney	O't - T Ot to '	7-0-4-1
Mar	7 18		19a. Informant's Name/Relationship (Type, Print) James W. Schwalenberg, Jr./son					City or Town, State, 2	zip Code)
re,	E E E		20a. Method of Disposition 20b	. Place of Dispo	Joy Lee Position (Name of matory or other place			Oc. Location - City or	Town, State
E O			1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		1 Cemeter	-	2-2006 St	uitland,Ma	ryland
Baltimore, Maryland 21215-0036	permit. Page Department of Important; If eny injury or once.		21. Signature of Funeral Service Licensee		2. Name and Addres		D		D 20716
_	205 g		18 Jary Hedgman Mois					Suitland,M	D 20746 Approximate
1			23a. Part 1. Enter the disease, or complications that caused the deshock, or healt failure. List only one cause on each line. Immediate Cause (Final	all. Do not one	Line P.	g, such as cardiac	or respiratory arres	201	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Chvouc (Due to (or as a cons		21102 10	monav	7 0150	esc	>10 years
4.	Examiner		Sequentially list conditions b.						
	Sit %	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	equence of):					
in	xecut	Examiner	that initiated events c. Due to (or as a cons	sequence of):					
760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	cal	d						
99	death certificate I rattending physi I for use as the t	Physician/Medi	IF FEMALE:						
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant at time of the past 12 months?	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.O.	at the de by the a tached	yslc	1 ☐ Yes 2 ∰No 9 ☐ Unknown 9 ☐ Unknown	ideall SL					
	res that igned b be deta	by PI	Part II. Other significant conditions contributing to death but not			en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	v require been sig should b	ted !	History of Hypenthyvo	idisu	u _		1 7×es	2 □ No 3 □ Pr	obably 4 Unknown
of Vital Records,	law r	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
аН	ician: The law certificate has rector, page 2 a							No 1 □ Yes	2 No
<u>X</u>	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗽 🗸 🗸 🗸 O	□ ER/Outpatier	nt 3 DOA Oth	00	n <i>(Check only</i> one me 5.1 ∜ Resider	nce 6 Other (Spe	city)
	ding Phy h. After the funeral o		27. Manner of Death 1. Manner o	28b. Time of		y at	28d. Describe hov		
Siol	eath. or: Af the fu	catle	2 Accident Investigation			Yes 2 □No			
Division	I or Attendi after death. Director: A	Certification:	4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t nome, tarm, str xify)	reet, factory, office		City or Town,	eet and Number or Ru State)	urai Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, deat	h occurred at the tin	ne, date and place,	and due to the car	use(s) and manner as	s stated.
	the Ho in 24 in the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	ination and/or in					lle
	To T To T	Σ	29b. Signature and title of certifier level al	2 111	29c. Licenso	0 4 9	129 1	d. Date signed (Mont	1. Day, Year) 2006
0			30. Name and address of person who completed cause of death (I				, v		~ 0/ 0 8
1/	(10)				boro Pike	Upper 1	Marlboro.	Marvland	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32.						
>	Regist	rar	NOV 3 0 2006	Uparte					

			For State Registrar	State of Ma	ırylar	-	artmen rtificat			and M	lental Hy	gien	006	40145
	Physici	an	1. Decedent's Name (First, Middle, Las	•							2. Date of De	Da	ay Year	3. Time of Death
	/Medic		Dorothy Lambert S								Noveml		21, 200	
	Examir	er	4a. Facility Name (If not institution, give Crofton Convales		_			fton	Location of	of Death			c. County of De inne Aru	
	Funeral		5. Social Security Number 6. S			last birthday)	If Under	1 Year	If Under		8. Date of Bir (Month, Da			irthplace (State or Foreign
**	Director		577-09-4432 Usual Residence of Decedent	□M 2 X)F	90	Yrs.	Months	Days	Hours	Min.	06/04/	1916	New	Jersey
	Maryland a-f show iffied at	ctor	10a. State 10b. County Maryland St. Mary	's		y,TownorLo at Mil:								10d. Inside City Limits 1 ☐ Yes 2 No
	or 28	Dire	10e, Street and Number				10f. Zip					-	itizen of What C	Country?
	e 23a	ral	19835 Fall Court	40 W - D		0 140	206					USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f show any Injury or other treumatic event, the Medical Exeminant must be notified at anote.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates:		I	was Deced f Yes, spec 1 \By Yes :	ofy Cubai	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecfy Yes or No Rican, etc.))- 	14. Race - Am Black, Wh Specify:	
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced	kind of war	rk done d	urina most	t of worki	na	16b. h	Kind of Busines	
2	han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT us	se retired,)		9	0		
22	Hygie Hygie ther th		12 17. Father's Name (First, Middle, Last)			Telepl	none	Uper		er's Name	(First, Middle		municat	lons
Baltimore, Maryland 21215-0036	ould be I Mental I Marked o	To Be	John Fay						Myrt	le L	ambert			
Mar	id 2 sh ith and ith and 27 Is m treum		19a. informant's Name/Relationship (7) George Shegogue/	,, ,								-	or Town, State, D 20725	
ē,	s 1 an f Heal flem 2 other		20a. Method of Disposition		20b. F	Place of Dispo					ate		ocation · City o	
E O	Page: ient of nt: If I		1 MBurial 2 □Cremation 3 □ 4 □Donation 5 □Other (Specify						1	11/2	5/2006	Bre	ntwood,	MD
alti	permit. Departm Importe any Inju		21. Signature of Funeral Service Licen	see										ral Home
<u> </u>	89 = 9		> Kellet			16	5000	Annaj	polis	Roa	d Bowie	e, M	D 20715	
**	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin a. Dementia	ө. Э		er the mod	e of dying	, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Between Onset and Death Years
	Examiner			Due to (or as a		,	erebr	ovas	cular	Dis	ease			Years
	outed id	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a										
8760,	rate be executed hysicien and the burial-transit	cal	resulting in death) Last	Due to (or as a	conseq	uence of):								
P.O. Box 6	nding puse as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2	2 ☐ Feta	Ideath 3	Ectopic pro						23d. Date of de Month	elivery Day Year
ds, P.	uires that the death signed by the atte id be detached for	by	Part II. Other significant conditions of	entributing to death bu	t not res	ulting in the ur	nderlying ca	ause give	n in Part I.		9			to the cause of death?
lecor	s faw requir has been si e 2 should	Completed									24a. Was	osy	prior to	utopsy findings available completion of cause of
ᆵ	n: The										1 ☐ Yes	med?	death?	s 2 No
<u> </u>	sicier certif recto	Be c	25. Was case referred to medical examiner?	Hospital:		50.0		Othe	-		(Check only o			
Division of Vital Records,	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	itlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	,	ER/Outpatien 28b. Time of Injury		8c. Injury Work	at AN INUI	2	ne 5 ∐ Resi 28d. Describe I		6 □Other (Sparry occurred	ecify)
Divisi	al or Atter s after dea of Director of in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At ho (Specif	ome, farm, stro	eet, factory	, office		2	28f. Location (3 City or Tou	Street a. wn, Stat	nd Number or F e)	Rural Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direction Direction by the Funerel Direction by the Funerel Direction by the Funerel Direction by the Funerel Direction by the Funerel Direction by the Funerel Direction By the By the Funerel Direction By the By the Funerel Direction By the By th	edical (29a. Certifier 1 X Certifying Phyone) 2 Medical Exem	/sicien: To the best of iner: On the basis of and manner state	examina	wledge, death tion and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s date an	s) and manner and place, and du	is stated. e to the cause(s)
	To the To the Comp	ž	29b. Signature and little of certifier	1	/	2		. License		4		29d. Da	ate signed (Mon	th, Day, Year)
)			M KaKest	non	01	19,1	10	_ 〕	120	> 1C	58	1	1/22/	06
			30. Name and address of person who	· ·				C	- 000	ח	4 . 300	207	1.5	
2.	Charles Charles	10	Rakesh Arora, MD 31. Date filed (Month Ov. Y2") 9 2	14300 Ga.			Lane	Suit	e 222	ROM	ie, MD	207	13	
	Sta Registr	ar	31. Date filed (Month Oay Y2")9 2	006	L J	K A	arth.	V						

		1	State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	Mental Hygier	ZHHb	40146					
	0		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death					
	Physicia /Medic	a!	John L. Scully, Jr.	November	26, 200						
1	Examin	er	4a. Facility Name (If not institution, give street and number) Collingswood Nursing & Rehab. 4b. City, Town, or Location of Deal Rockville	ith	4c. County of Deat						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr. Months Days Hours Mir		ar) 9. Birt	hplace (State or Foreign ountry)					
	Director		578-09-8215 XXM 2LF 85 Yrs.	Oct. 31,	1921 Wa	shington, DC					
	ow ow	-	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
	Mary a-f sh	to	Maryland Montgomery Silver Spring			1 ☐ Yes 2 € No					
	death with the Maryland ms 23e or 28e-f show rnust be notified at	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Co	untry?					
	23a	la l	3156 Gracefield Road, Apt. 310 20904		USA						
	er deg	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - Ame Black, Whit						
36	rs aft	by F	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 1 □ Yes 2 ☑ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates: WWII		SpecifyWhi	te					
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Ind other then "neturel", or Items 23e or 28e-f show event, I're Medical Exercirer must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	. Kind of Business/	Industry					
215	within 7 ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of we life. DO NOT use retired)	orking .							
21	ed wil	Co	12 General Agent		Life In	surance					
Maryland	12 should be filed within n and Mental Hygiene. Y is marked other than "raumatic avant, I'm Mental Mental avant, I'm Men	Be		ame <i>(First, Middl</i> e, Maid ine Downes	en Sumame)						
Σ	hould d Mer marke maric	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		v or Town, State.	Zip Code) 20904					
Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 is marked any injury or other traumatic a gnce.		Margaret C. Scully/ Wife 3156 Gracefield Road								
ē,	s 1 ar f Hea item othar	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or	Town, State					
E O	Page: ent o nt: if		1 反 Buriat 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cate of Heaven Cemetery	ember 2 2006 Sil	ver Spri	ng, Maryland					
Baltimore,	permit. Departm Importa any inju	Ì	21. Signature of Funeral Service Licensee Francis U.S. Name and Address of Eachilly in:								
8	88 2 2 8		(McLey) Cole 500 University Bly	vd, W, Silv		g, MD 20901					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory arrest,		Approximate Interval Between Onset and Death					
	Physician		Immediate Cause (Final disease or condition a. DNeumonico			Onset and Death					
	/Medical Examiner		Due (o (or as a consequence of):								
		-	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):								
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
ó	be executed sician and burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):								
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9	The law requires that the death certificate at has been signed by the attending physbage 2 should be detached for use as the	as h	IF FEMALE:								
Box	eath certific attending p	ian/l	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of del	ivery Day Year					
	at the dea by the a tached f	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)			,					
P.0	that the ed by detac	Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?					
ds	uires sign Id be	d by		1 🗆 Yes	2 No 3 Pr	obably 4 Unknown					
00	w requir s been si should	lete		24a. Was an	24b. Were au	itopsy findings available					
Re	The law cate has page 2:	Completed		autopsy performed	? death?	completion of cause of					
Vital Records,		BeC	25. Was case referred to medical examiner?	eath (Check only one)							
of V	hysici this cer al direct	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Spe	cify)					
D C	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how in	ijury occurred						
Sio	death. death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of thirty - At home, farm, street, factory, office	28f. Location (Street	and Number or P	Im/ Poute Number					
Division	after after Dirac	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, St		mar riodio rvairioor,					
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place								
	na Ho	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time, date	and place, and due	to the cause(s)					
	To th withir To th	Ž	29b. Signature and title entitier 29c. License number	29d.	Date signed (Mont	h, Day, Year)					
	1401		1 3 4 SMY 8 CVV MD D00624	3 S	11/2+	1,000					
	(0,,		30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) SAYEDM. ELSAYYAD 9715 Mcdily Conta D. 1	Rockville	OM,	20850					
:-	Sta Registi	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED M. ELSAYAP G1/5 Mcd. (*Center D.) 31. Date filed (Month, Day, Year) NOV 3 0 2006								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #5, pen = For F. H., TCHD, 11/29/06, Shb Certificate of Dooth 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 1259 DEBORAH M. SOMERS SEGER November 25 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner er 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F Hours Yrs. Director -4**9**-88 53 APRIL 6, 1953 NEW YORK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1XYes 2 No EASTON MD. TALBOT Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 21601 U.S.A. 25801 SAWGRASS COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No WHITE ٥ Specify: Specify: 3 ₩Widowed 4 □Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 7 ent of Health and Mental Hygiene.
nt: If Item 27 is marked other then "n ry or other treumatic event, Ite Mediry or other treumatic event, Ite Mediry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES PFITZINGER IVA M. LEACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOMERS / ADMISTRATOR 21 SASSAFRAS LANE BERLIN, MD. 21811 STUART R. Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CRM. CTR. 11-29-06 STEVENSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. Joseph M. Ostrowsh C.f.S.P. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, longer than the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, longer than the cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Me-Breast Cancer Physician years /Medical **Examiner** oholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown Month Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 2 No or Attending Physician: the funeral director, 25. Was case referred to medical examiner? 28. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours e To the Funerel C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Vovember 25 2006

Registrar

DHMH 17 Rev 1/2001

State

South washington St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abraham

Registrar's Signature

Daniel

NOV 2 9 2006

31. Date filed (Month, Day, Year)

			1 - For Stete Registrer	State of M	larylan		artment <i>tificate</i>			and M		gienę Reg. No.	dub	401	48
	Physici	an	Decedent's Name (First, Middle, Last	•			_				2. Date of Dea Month	Day	Year	3. Time of	Death
	/Medic			Ethel			Swart				Novembe	er 3	0, 2006	7:50	РМ
	Examir	er	4a. Facility Name (If not institution, give)		4b. City, T			f Death			County of Death		
			Avalon Manor Nurs 5. Social Security Number 6. Se		ne /in ure	last birthday)	If Under 1	erst	OWN If Under:	24 Hrs	8. Date of Birti		Washingt		
	Funeral Director				87	Yrs.		Days	Hours	Min.	Oct. 1	r, Year)		ntry)	r i-oreign
			Usual Residence of Decedent					1			OCE. 1	, 17	19 Mary	land	
	rylan how		10a. State 10b. County		10c. City	y, Town or Lo	cation						1	0d. Inside Ci	,
	e Ma Ba-f s	cto	MD Washing	gton	На	gersto	wn							1 X Yes	2 🗌 No
	ith the	Director	10e. Street and Number				10f. Zip 0	Code				10g. Citi	zen of What Cour	itry?	
	s 23e	rai	240 S. Potomac St			0 100		740					U.S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23e or 28e-f show early injury or other traumatic event, the Marical Examena traumatic event, the Marical Examena traumatic event, the Marical Examena traumatic event.	by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		Vas Decede fYes, specif Yes 2		spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.	
Ş	thou sture	edt	15. Decedent's Edu			16a. Deced	lent's Usual	Occupa	tion			16b. Kir	nd of Business/In-	dustry	
75	72 oir 72	Completed	(Specify only highest grad		6.1	(Give life. L	kind of work OO NOT use	done di retired)	uring most	of worki	ng			300 K y	
2	d with giene	mo	6	College (1-40)	3+)	Heat	Treatn	nent				Fair	rchild A	ircraf	t
g	al Hy othe	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
<u>a</u>	Ments Ments arked	ToE	James Oscar Grubbs						Mabe	1 Ma	e Gibne	ey .			
lan	2 sho and Is mu	Y 5	19a. Informant's Name/Relationship (T)										Town, State, Zip	Code)	
≥,′	and ealth m 27		Roy R. Manning/Son	1	1	the second second			Ave.,	44	gerstown				
Baltimore, Maryland 21215-0036	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F	Removal from State	C	lace of Dispo- emetery, cren	natory or oth	er place			ate		cation - City or To		
₽	t. Pa rtmen rtant: rjury		* 4 □ Donation 5 □ Other (Specify)		Smi	thsbur							hsburg,		
Ba	permi Depa Impo eny ir	Į.	21. Signature of Funeral Service Licens 5. Mall Signature	10		16	01 Pe	nnsy	lvan:	ia A	ve., Ha	gers	eral Cha town, MI		<u> </u>
	Pnysician /Medical	8 1	23a. Part1. Enter the disease, or compositions shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Illitations that cause ne cause on each I	d the death ine. a consequ	bra uence of):	er the mode	nf nf	Such as	tio	ir respiratory arm	est,		Approximate Interval Bety Onset and E	veen
	Examiner	<u></u>	Sequentially list conditions,	b. Due to (or es	Atr	rial	- +	- (\	o √ ,	la	ion	_			
	nsit	Examiner	Sequentially list conditions, if any leading to this educe cause. Enter Underlying Cause (Disease or injury		Cond	esti	JL	\mathcal{C}	and	io w	yo pal	hy			
<u>,</u>	cate be executed obysician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):					0				
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.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3 🗆	Ectopic prec Other (spec					2	3d. Date of delive Month	-	'ear
œ.	s that ined b e deta	by Ph	Part II. Other significant conditions con	ntributing to death t	out not resu	ulting in the un	derlying cau	ıse givei	n in Part I.		23e. Did to	bacco us	se contribute to th	e cause of de	eath?
ğ	w require been sig should b	edk	1) < W	ent; a	`						1 □ Y	es 2	No 3□Prob	ably 4 💯	nknown
Division of Vital Records,	hysician: The law re nis certificate has be I director, page 2 sho	Completed									24a. Was a autops perfori	sy ,	death?	osy findings a apletion of ca	vailable luse of
ita	sian: artifica ctor,	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or	4			
<u>></u>	Physic this ce al dire	10	1 Yes 2 No			ER/Outpatient			4 179UI	sing Hon	ne 5 Reside	ence 6	☐Other (Specify)	
בַ	ding Ph h. After th tuneral	iuo	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		C. Injury Work			8d. Describe ho	ow injury	occurred		
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DIX	of or Attendate after death Director:	Certification:	4 Homicide determined	28e. Place of the building, et	iury - At hoi c. (Specify	me, farm, stre	et, factory, o	office		2	28f. Location (Si City or Towi		Number or Rura	Route Numb	ier,
	To the Hospitel or Attending Physician: whith 24 hours after death. To the Funeral Director. After this certific completely tilled in by the tuneral director,	edical C	29a. Certifier 1 Certifying Phy. (Check only one)	sicien: To the best ner: On the basis of and manner st	f examinat	wledge, death ion and/or inv	occurred at estigation, in	the time	, date and nion, death	place, a	and due to the ca	ause(s) a ate and	and manner as sta place, and due to	ated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	market				License		a r	2		signed (Month, L		
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			30. Name and address of person who co			23а) (Туре, Р	Print)	112	6	09	al	ct	_		
21	1-0			Un 51					Han	215	town	, ^	VD 71	740	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ars Signat	ure M. A.	adis		7	I		_			

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Registrar

31. Date filed (Month, Day, Year)

DEC

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DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Martha Glennette Schmanns /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Doonsbore heedy Home If Under 1 Year | If Under 24 Hrs. (). Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Bifti plece (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1934 Arkansas Director 429-60-8721 March 4. Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Exerciter : ust be rediffied at 1 ☐ Yes 2 ☐ No Director Maryland Washington 7701 River Rock Court Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 7701 River Rock Ct U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic and Mental Hygin injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: It item 27 Is marked o John Lail Verna Sue LaFever ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Pelletier / Daughter 7701 River Rock Ct. WilliamsportMaryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Port Washington, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Nassau Knolls Cemetery12/05/2006 | New York 21. Signature of Funeral Service License 22. Name and Address of Facility Rest Haven Funeral Chapel any 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ... line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** /Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 Wounc 1 Yes 2K No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Surring Home 5 Residence 6 Other (Specify) NO Certification: To 1 🗌 Yes 1 Inpatient 2 ☐ EB/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours. To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and nd address of person who completed cause of death (Item 23a) (Type, Print) COPPECES, unD itzy oper con Day Year) 32. Registrar's Signature State Ü Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and attending physician for use as the burial ed by the a signed by After this certificate has been si funeral director, page 2 should I 24 hours after death. e Funeral Director: A filled in by completely To the I within 2

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be.

Physician

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

2

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

8

State Registrar

29b. Signature and title of certifier rosoner 29c. License number

1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

D32288

December 6, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

OSLER DRIVE TOWSON, MARYLAND 21204 7621 DROSSNER M.D. MICHAEL

31. Date filed (Month, Day, Year)

DEC 1



06-09215 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jesse L. Thomas 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day December 4, 2006 **Medical Examiner** THOMAS Jessie L. Thomas 4a. Facility Name (if not institution, give street and number) 4c. County of Death Salisbury Wicomico Peninsula Regional Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number **Funeral** Country) CANNAH, Days Hours Director SEP 14,1929 1 X M 2 F 77 258-32-4030 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b Count 28a-f show FRANKFORD DELAWARE UNITED STATES hours after death with the Maryland Director 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 23a or 2 19945 DELAWARE AVENUE UNITED STATES 78 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 Married 2 **X** No Yes BLACK 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 X Widowed à "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) AGRICULTURE other than the Medical POULTRY WORKER Baltimore, MD 21215-0036 9 Pages 1 and 2 snows connent of Health and Mental Hygiene tant: If item 27 is marked other the Mer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **BROWN** MINNIE GRIFFIN **GLENN** 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ FRANKFORD, DE 19945 ISLER (DAUGHTER) P.O. BOX 170, DORA BELL 20b. Place of Disposition (Name of cemetery, 20c Location - City or Town, State 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State DEC 9,2006 BISHOPVILLE, MD ZOAR GOLDEN ACRES Donation 5 Other Specify 22. Name and Address of Facilit ion ture of Funer | Service License WATSON FUNERAL HOME MO 1361 M0 1361 MTTLSBORD DELAWARE 19966

atto 5 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Part I. Enter the ease, or confi Physician /Medical a Asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Displacement of tracheostomy tube Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. Physician/Medical M AMENDED #1,23a-b,PII,27,28a-f, perME, g864, 2/2/07 TT X UNPENDED 23d Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy

attending physician and or use as the burial - trans To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

Ps ģ

Completed

Be ٩ 27

Certification:

Medical 29b

past 12 months?	Live birth 2 Fetal death 3 Ectopic pro	agnancy Month Day Year
Part II. Other significant conditions cor	ntributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
laryngeal carcinoma;	recent pneumonia; hypertensive	1 Yes 2 No 3 Probably 4 Unknown
atherosclerotic cardi	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	
pulmonary disease		1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	26.Place of Death (Ch	eck only one)
examiner? —1 ✓ Yes 2 No	other 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other 4 N	ursing Home 5 Residence 6 Other:
27. Manner of Death	28a Date of Injury 28b Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 5 Pending 2 Accident Investigation	12/4/2006 Fnd: 3:30 am	unknown
3 Suicide 6 X Could not be	28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 101 E. Delaware Ave.
4 Homicide determined	(Specify) nursing home	Delmar, DE
CHECK UNITY	To the best of my knowledge, death occurred at the time, date and place,	
	the basis of examination and/or investigation, in my opinion, death occur d marche stated	red at the time, date and place, and due to the cause(s)

29c License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Time of Death

0432 hrs

GA

Yes 2

Death

29d Date signed (Month, Day, Year)

December 5, 2006

State Registrar

31. Date filed (Month, Day, Year) 2006

Susan Hogan MD.

ddress of person who completed cause of death (Item 23a) Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #31, perDVR, tate of Maryland TDepartment of Health and Mental Hygiens. 40153 06 Amen<u>ded#5.12</u> Physicia /Medica Examine **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified at apries. Once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

1 /	06 Hegistrar N	1.S. Ke	nt Co				OT LITTLE	oute of	Doui	•		Heg. I	10.		
1	1. Decedent's Name	e (First, Middle	a, Last)	TH	mF	'SO 14	/				2. Date of D Month		ay	Year	3. Time of Death
ľ	4a. Facility Name (f not institution	n, give street an	d number)		,	4b.	City, Town,	_		1		c. County		
	UNIVERSI	TY OF A	nony/1/A	VD Site	CKI	esum	9	121-1	Timo						
	5. Social Security N	lumber 5929	6. Sex 1 ☐ M 2 ☐		(In yrs.	last birthda 7 Yrs.	Mo	Inder 1 Year nths Days		Min.	8. Date of Bi (Month, D	ay, Yea	939	Co	nplace (State or Foreign untry)
	214-36- Usual Residence of	Decedent		X								l	7.5.7		11)
	10a. State	10b. County			10c. Cit	y, Town or	Location	n							10d. Inside City Limits
013	MD	Ken	nt		C	hest		-							1 ☐ Yes 🔏 ☐ No
Dy runeral Directo	10e. Street and Nu							of, Zip Code				10g. (Citizen of V	What Co	untry?
8	7663 A:	iry Hi		Decedent 8	ver in 11	S 1:		21620		rigin? (S	pecify Yes or N	0-	US/		rican Indian.
	1 Never Marr	ied 2 🕏 Marn	ied 1 □	ed Forces? Yes 2 ℃ N			If Yes	, specify Cut	oan, Mexic	an, Puert	o Rican, etc.)		Blac	ck, White	e, etc.
	3 Widowed		I II Y O	s, Give r or Dates:			1 🗆 Y	′es X □ No	Specif	y :			Specify	v: B1 a	ack
Completed	(Spec	15. Decedent cify only highes	t's Education st grade comple	eted)		16a. Dec	cedent's ive kind a. DO N	Usual Occu of work done OT use retire	pation during mo	ost of wor	king	16b.	Kind of B	usiness/l	Industry
шс	Elementary/Second 1.2		Colle	ege (1-4or 5	+)			tion				Carr	inhe'	11'	Soup Inc
a l	17. Father's Name		Last)			1					ne (First, Middle				b boup inc
0	Morris	Blake	s, Sr.						The	lem	a Blak	e			
	19a. Informant's N			")		19b. Ma	ailing Ad	dress (Stree			rai Route Numi		or Town,	State, Z	Tip Code)
	James '	Thomps	on-Hus	sband		766	3 A	iry H	i11_	Bd_	Cheste	rto	wn.	MD	21620
	20a. Method of Dis	•	3 □Removal	from State	20b. P	Place of Dis cometery, c	sposition cremator	(Name of y or other pla	ace)		Date	20c.	Location -	City or	Town, State
	4 Donation			moin Otato	As	bury	U.	М.	1	2/0	2/06	_Ch	este	rto	wn, MD
	21. Signature of Fu	uneral Service		2	7	001	22. Nar	me and Addr	ess of Fac	ility Ke:	nneth	Wal	lev.	Fur	neral
	- //-	pec a											olis	5, M	ID 21401
	23a. Part . Enter shock, or head immediate Cause disease or condition	(Final	only one cause		PS/		enter the	e mode of dy	ing, such a	is cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
	resulting in death)		Du	ie to (or as	conseq	uence of):		En. l.							
Je	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	onditions, nmediate erlying	b	ie to (or as	a conseq	uence of):	7	FAIla	RE						-
Examine	Cause (Disease or that initiated event: resulting in death)	S	c	Rig	4T.	Lun	90	An C	en						
Û	rosalting in additing	Luot		ie to (or as a	a conseq	uence or):									
Medical			d												
MAIN MAIN	IF FEMALE: 23b. Was deceden	nt pregnant		s, outcome			3∏Edo	pic pregnanc	01/					te of deli	,
21018	in the past 12	X No	4 🗆 1	Pregnant at Unknown				er (specify)	-y				Mo	onth	Day Year
Physici	9 ☐ Unknow				it not rec	ulting in the	e under	vina eause a	Iven in Dar	t I	23a Did	tobacc	n use con	ribute to	the cause of death?
Completed by	Partii, Other aigin	neart conditi	ona contributing	, to death be	11 1101 163	oung in the	e di iden	ying cause g	IV O II II I PAI		6.0	1	2 □ No		obably 4 Unknown
2											24a. Wa	s an	24b.	Were au	topsy findings available
											auto	opsy formed?	,	death?	topsy findings available completion of cause of
D C	25. Was case refe	rred to medical	i i						26 Pla	ce of Dea	th (Check only	-/`	No	1 Ll Yes	2 No
0	examiner?] No	Hospital:	1 🗌 Inpatie	nt 2 🗆	ER/Outpat	tient 3	DOA O	thac		ome 5 Res		6 □Oth	ner (Spec	cify)
-	27. Manner of Dea	th 5 🗆 Pendin	28a.	Date of Injur (Month, Day	y (Year)	28b. Time Injur		28c. Inju			28d. Describe				
alle	2 Accident	investi	gation				N		Yes 2	□No					
	3 ☐ Suicide 4 ☐ Homicide	6 □ Could i determ	ined 286.	Place of Injubulged	iry - At hi c. <i>(Specif</i>	ome, farm, fy)	street, f	actory, office	•		28f. Location City or To	(Street own, Sta	and Numb ate)	er or Ru	ral Route Number,
2	23a Certifier	1 € Gertityin	ng Physician: 1	To the best o	d my kno	wladge de	eath occ	urred or tha	time date	and plans	and directo the	o causo	(e) and va	shiper as	ethlad
edical Certification:	(Check only one)	2 Medical	Examiner: On	the basis of manner sta	examina	ation and/or	r investiç	gation, in my	opinion, d	eath occu	rred at the time	, date a	ind place,	and due	to the cause(s)
ž	29b. Signature and	title of certifie	Iny w	1 11	1))		1	17 6		S E 1751		•		n, Day, Year)
	30. Name and add	res of erson	who mpleted	cause of d	eath (Iten	n 23a) (Tvo	pe, Print								7
	MAZ	AN	FILS	HYI	N	. 1/	miV	ern to	nl	Mar	Mand	14	adi.	lost	lenter

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Physician /Medical

Examiner

To Be Compieted by Funeral Director

Funeral

Director

Medical Certification: To Be Completed by Physician/Medical Examiner

31. Date filed (Month, Day, Year)

DEC 0 4 2006

Please ¹						_	
For State	State of Ma		partment of e <i>rtificate of</i>	Health and M * <i>Death</i>		2006	40154
Registrar 1. Decedent's Name (First, Middle, Las	t)		J. IIII CALE UI	Joann	Reg. 2. Date of Death		3. Time of Death
	E TURNER V	ORWERCK			Dec C	Day 2001	0 210 PM
4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Deatl	h
Fahrney-Keer	dy Norsir	1a Homi	e Boo	nsbare		washir	ngton
5. Social Security Number 6. Sec. 238-14-0820	7. Age ☐ M 2 TyrF	(In v)s. last birthda 94 Yrs.	y) If Under 1 Yea Months Days	Hours Min	8. Date of Birth (Month, Day, Ye Aug. 20,	9. Birth	nplace (State or Foreign untry)
Usual Residence of Decedent	X	94 115.			Aug. 20,	1912 Sou	th Carolina
10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Maryland Washing	ton	Boonsbor	0				1 ☐ Yes 2 ☐ No
10e. Street and Number	-		10f. Zip Code		10g.	Citizen of What Co	untry?
8507 Mapleville Re				713		U.S.A.	day to di
11. Marital Status	12. Was Decedent E		 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:	,	1 ☐ Yes 2 N	o Specify:		Specify: Wh	ite
15. Decedent's Ed	ucation	16a. De	cedent's Usual Occ	upation	16b	. Kind of Business/	
(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+	-)		e during most of work red)			
		S	eamstress			estern Co	at Pad
17. Father's Name (First, Middle, Last) Farley Turner				18. Mother's Nam Susan Pa	e (First, Middle, Maid rlor	den Sumame)	
	Suna (Pri=4)	405 **	illing Addess: (C)			ibi or Town Chair 3	Tip Codol
John R. Vorwerck		1		etand Number or Rur eld Road,			
20a. Method of Disposition	, ilasballa	20b. Place of Dis	position (Name of		1.4	. Location - City or	
1 Burial 2 Cremation 3 \(\) 4 \(\) Donation 5 \(\) Other (Specify			rematory`or other p	tory 12/5	106 5	1 + h a h	Manualand
21. Sign fure of uneral Service Liven	aria C	100 CM	22. Name and Add	ress of Facility		.50,000	Maryland
take C	The			DAILEY & H MARKET S			
23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused in	the death. Do not e					Approximate Interval Between
Immediate Cause (Final disease or condition	Lish e.	Levely	· Can	disvosa	0 - 1	is in	Onset and Death
resulting in death)	a. Due to (or as a	consequence of):		0 1000321	e uy	1+CCX A	567
Sequentially list conditions,	b. 1)-c	ment le	\				20¥
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					/
Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for se a	consequence of):					
	Due to (or as a	consequence or,					
•	d						
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of deli	very
in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		3 □Ectopic pregnar 5 □ Other (specify)	icy		Month	Day Year
9 Unknown	9□ Unknown						
Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause	given in Part I.	23e. Did tobacc	co use contribute to	
					1 🗆 Yes	2 No 3 Pr	the cause of death?
							the cause of death? obably 4 Delnknown
					24a. Was an autopsy	prior to d	obably 4 Honknown
						prior to death?	obably 4 Adnknown topsy findings available completion of cause of
25. Was case referred to medical examiner?					autopsy performed	prior to death?	obably 4 Ninknown topsy findings available completion of cause of
examiner? 1 Tyes 2 No	Hospital: 1 ☐ Inpatier		tient 3 DOA	other: 4 Nursing Ho	autopsy performed 1 Yes 2 Act (Check only one)	d? prior to death? No 1 □ Yes e 6 □ Other (Spec	obably 4 Denknown topsy findings available completion of cause of
examiner? 1 Yes 2 No 27. Manner of Death 1 Alatural 5 Pending	28a. Date of Injun (Month, Day	28b. Time	e of 28c. In	other: 4 × Nursing Houry at ork?	autopsy performed 1 Yes 2 Ch	d? prior to death? No 1 □ Yes e 6 □ Other (Spec	obably 4 Denknown topsy findings available completion of cause of
examiner? 1 Yes 2 Mo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	e of 28c. In y M	Other: 4 Nursing Hoursing Hoursing Hours at lork? Yes 2 No	autopsy performed 1 Yes 2 Xeh (Check only one) ome 5 Residence 28d. Describe how i	d? drain: INo 1 □ Yes e 6 □ Other (Specinjury occurred	obably 4 Deinknown topsy findings available completion of cause of 2 No
examiner? 1 Yes 2 No 27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	e of 28c. In	Other: 4 Nursing Hoursing Hoursing Hours at lork? Yes 2 No	autopsy performed 1 Yes 2 Act (Check only one)	prior to death? No 1 □ Yes e 6 □ Other (Specinjury occurred	obably 4 Deinknown topsy findings available completion of cause of 2 No
examiner? 1 Yes 2 No 27. Manner of Death 1 Selatural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injun (Month, Day 28e. Place of Injun building, etc	y Year) 28b. Time Injur ry - At home, farm, (Specify)	e of 28c. In W 1 street, factory, office	other: 4 Nursing Houry at ork? Yes 2 No	autopsy performed 1 Yes 2) An (Check only one) ome 5 Residence 28d. Describe how i	prior to death? No 1	topsy findings available completion of cause of 2 No
examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 2 Homicide 1 Certifying Ph	28a. Date of Injun (Month, Day	Year) 28b. Time Injur ry - At home, farm, (Specify) f my knowledge, de examination and/of	e of 28c. In W 1 1 street, factory, office the occurred at the	other: 4 Nursing Houry at ork? Yes 2 No	autopsy performed 1 □ Yes 2 ☑ th (Check only one) ome 5 □ Residence 28d. Describe how i 28f. Location (Stree City or Town, S and due to the causi	prior to death? No 1 Yes e 6 Other (Specinjury occurred at and Number or Rulliate) e(s) and manner as	topsy findings available completion of cause of 2 No No Notate Number,
examiner? 1 Yes 2 No 27. Manner of Death 1 SAlatural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Exam	28a. Date of Injun (Month, Day) 19 28e. Place of Injun building, etc	Year) 28b. Time Injur ry - At home, farm, (Specify) f my knowledge, de examination and/of	a of 28c. In W 1 1 28c. In W 1 1 28c. In which was also coursed at the investigation, in my 29c. Lice	other: 4 Nursing Hours at ork? Yes 2 No e time, date and place, opinion, death occur nse number	autopsy performed 1 Yes 2 Sch (Check only one) ome 5 Residence 28d. Describe how i 28f. Location (Stree City or Town, S and due to the causered at the time, date	prior to death? No 1 Yes e 6 Other (Specinjury occurred at and Number or Rullitate)	topsy findings available completion of cause of 2 No No No North Number, stated. to the cause(s)
examiner? 1 Yes 2 No 27. Manner of Death 1 SAlatural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	28a. Date of Injun (Month, Day) 19 28e. Place of Injun building, etc	Year) 28b. Time Injur ry - At home, farm, (Specify) f my knowledge, de examination and/of	a of 28c. In W 1 1 28c. In W 1 1 28c. In which was also coursed at the investigation, in my 29c. Lice	orker: 4 Nursing Hours at ork? Yes 2 No e time, date and place, opinion, death occur	autopsy performed 1 Yes 2 Sch (Check only one) ome 5 Residence 28d. Describe how i 28f. Location (Stree City or Town, S and due to the causered at the time, date	prior to death? No 1	topsy findings available completion of cause of 2 No No No North Number, stated. to the cause(s)

State

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** EVELYN STINE WISE /Medical NOVEMBER 30,2006 8:30A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, July 9 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) 1 M 2 T 218-40-3463 85 July ΜĎ Director 1921Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show be notified at 28a-f show 1 ☐ Yes 2 X No MD Frederick Director Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7205 Dogwood Lane 21769 items 23a USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify. Specify: White þ 3K Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) stock clerk retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell H. Stine Nannie Schroyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is Bonnie Simons (Daughter) 7299 Beechtree Ct., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages M Burial 2 ☐ Cremation 3 Removal from State Lutheran cemetery 12/4/2006 Middletown, MD injury 5 ☐ Othe (Specify) 4 Donation Sanature of Funeral Service License ²Donald B• Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Part Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician pais disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Mellitus 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page this certificate 2 1 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Box 68760. P.0. Records, Division or Vital To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t

> State Registrar

0

DHMH 17 Rev 1/2001

DEC 0 4

29b. Signature and title of certifier

SYO

HADIE MONICLAILE 100 31. Date filed (Month, Day, Year) 2006

and manner stated.

mD

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

29d. Pate signed (Month, Day, Year)

06

ENEDERACK MU 2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1- State Registrar Amended #23a per MD- FCHD/tmCertificate of Death 12/4/06 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** JUNE IDA WALTERS NOVEMBER 28. 2006 9.564 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 25, 1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs. 81 Maryland 219-14-7886 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County r 28a-f show notified at 1 ☐ Yes 2 X No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n States 21703 United 502 K, Leahy Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status "natural", or items dical Examiner m Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: White Specify: Completed by 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other than "natu (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Supervisor 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Catherine Winpigler is marked Walter н. Horman Grace 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6315 Fulmer Rd./ Frederick, Maryland Nancy Lee Thomas / Daughter item 27 Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If its any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of 12/01/2006 | Frederick, Maryland Mount Olivet Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 23a. Part1. En a the disease, or complications that caused the deal...
shock, or heart failure. List only one cause on each line.
Probable Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate use (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transi and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Stage renal DISYASY Completed Cardiamyapathy 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No Diabetes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

certificate be executed Box 68760. P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

or Attending Physician: s after deural Director: Aff filled in by within 24 hours a

To the Funeral I

completely filled Hospital

To the I

29a. Certifier (Check only one)

29b. Signature and title of certifier

State Registrar

Shah 65C 31. Date filed (Month, Day, Year)

DEC 0 4

2008

Thomas egistrar's Signatur

and manner stated.

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

50060417

29d. Date signed (Month, Day, Year)

		-	_ FOI	partment of Health and Mer ertificate of Death	ntal Hygiene Reg. No.	
			Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day	3. Time of Death
	Physicia /Medic		Edna R. Watkins	No	vember 28	M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death
Ber.		Щ.	Homewood at Crumland Farms	Frederick If Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Frederick
×.	Funeral Director		5. Social Security Number 216-18-9505 6. Sex 1 M X F 7. Age (In yrs. last birthda	Months Days Hours Min.	(Month, Day, Year) 28, 19	9. Birthplace (State or Foreign Country) 912 Maryland
			216-18-9505 94 Usual Residence of Decedent	r.e	D. 20, 19	•
	how	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	se Ma	Director	Maryland Frederick	Frederick		1 ☐ Yes 2 XNo
	with the		10e. Street and Number	10f. Zip Code		izen of What Country?
	ns 23	eral	7407 Willow Road 11. Marital Status 12. Was Decedent Ever in U.S. 1	21702 3. Was Decedent of Hispanic Origin? (Specify	/ Yes or No-	nited States 14. Race - American Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel; or items 23e or 28e-f show if item 27 is marked other than "naturel; or items and items and other than or other traumatic event, it is Marical Examinar must be notified at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puèrto Rid 1 ☐ Yes 2 ☑ No Specify:	an, etc.)	Black, White, etc. Specify: White
21215-0036	2 hou	ted	15. Decedent's Education 16a. De	cedent's Usual Occupation ve kind of work done during most of working	16b. Ki	ind of Business/Industry
215	ithin 7 18. 18. "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	b. DO NOT use retired)		
2	led w lygier her th			ninistrator 18. Mother's Name (F	iret Middle Maiden	Electric
Maryland	ntal H Bd ott	Be	17. Father's Name (First, Middle, Last)			
ž	should and Men s marke umatic	10	Jesse James Rippeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mi	tilling Address (Street and Number or Rural R	ie Virgin	
N N	nd 2 s lith an 27 Is trau			31 Springfield Rd., D		
ē,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Dis	position (Name of Date rematory or other place)	20c. Lo	ocation - City or Town, State
E	Page:		1 Lagurial 2 Cremation 3 Linemoval from State	vet Cemetery 12/2/2	2006 Fr	rederick, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 li eny injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sta		neral Home
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١,			23a Part1, Enter the disease, or complications that daysed the death. Do not shock, or heart failure. List only one cause or each line.	enter the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)			2 W88 (C)
	Examiner		Due to (or as a consequence of):	4, 1)
	6.	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	1775104		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
ó	death certificate be executed e attending physician and nd for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consiquence of):			
8760,	ate be hysici ihe bu	dlcal	d			
<u>3</u>	entific ling p	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	eath certific attending p	Physician/Me	in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
o.	는 도 약	ysic	1 Tes 2 Ho 9 Unknown 9 Unknown	S Cities (specify)		
σ.		by Ph	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
rds	requires een sign rould be				1 🗌 Yes 2	□ No 3 □ Probably □Unknown
ecords	> Q 70	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
α	9 4 9	Completed			performed?	death?
Vital	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)	
of \	S S	ဥ	Hospital: 1 Inpatient 2 ER/Outpa		5 Residence	
	ding f	lo ::	27. Maprier of Déath Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation (Injure (Nonth, Day Year))		I. Describe how injur	y occurred
Division	Attending r death. Bctor: Afte by the fune	fica	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm,			nd Number or Rural Route Number,
<u>S</u>	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State	<i>1)</i>
	To the Hospitel or Attending Ph witin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do not be best of examination and/o and mapper stated.			
	To the wittin 2. To the corr plet	Me	29b. Signature and tiple of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
)	/-		MAAN In	MDD16428		11/30/06
	10		30. Name and addre of person the completed cause of death (Item 23a) Ty	Street, Frederick, M	21701	10000
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 4 2006 32. Refistrar's Signature	A		

State of Maryland / Department of Health and Mental Hygien [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ZADA WALSTON WILGUS 12:29PM 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbyr Wicomico 5. Social Security Number 8. Date of Birth (Month, Day, Y 7-7-1904 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🂢 F Director 221-34-8358 102 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Mode ir than "naturel", or Items 23s or 28s-f ehov The Medical Examiner must be notilied at Director 1XYes 2 □ No DELAWARE SUSSEX BETHANY BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33320 WALSTON WALK COURT 19930 death 1 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ Specify: WHITE 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER NONE 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS G. WALSTON MINNIE ANN COFFIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE W. MCCABE/ DAUGHTER POST OFFICE BOX 111, BETHANY BEACH, DE. 19930 20b. Place of Disposition (Name of Camatex, Framatox or other place)
MARINER FS BETHEL
CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe 3 Removal from State 12-3-06 OCEAN VIEW, DELAWARE 21. Signature of Funeral Set MELSON FUNERAL SERVICES. LTD. WEST AVE, OCEAN VIEW, DELAWARE. 19970 23a, Part1, Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Day Year 5 Other (specify) ed by the a sete hes been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 res 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 PR/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Matural 5 Pending after death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a 1 Contrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Description Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) H50497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) use of death (Item 23a) (Type, Print)
100 E. Carroll St. Salisbury MD. 21801 BA 5 hris Snyder, M.D. 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

DEC 0 4 2006

221-34-835

Zada 1

State of Maryland / Department of Health and Mental Hygiene

For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DECEMBER 2, JAMES FRANKLIN WEBB 2006 4:14 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 630 KIMBERLY WAY STEVENSVILLE **QUEEN ANNE'S** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 F 55 215-60-6703 Yrs OCTOBER 15, 1951 MARYLAND Director Usual Residence of Decedent the Maryland r 28a-f show 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MARYLAND QUEEN ANNE'S 1 ☐ Yes 2 X No STEVENSVILLE Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ir then "natural", or items 23a or the Medical Examiner must be r 630 KIMBERLY WAY 21666 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION GAS & ELECTRIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGE HERBERT WEBB MARY BLANCHE HIGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Item 27 i LILLIAN WEBB/WIFE 630 KIMBERLY WAY, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER 20c. Location - City or Town, State 5 permit. Page Department of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 12/04/2006 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GRITIS intertail /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical use as the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death signed by the at d be detached for 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 Probably 4 Unknown should I 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? hes pertens 100-1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury To the Hospital or Attendia within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041339 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 LOVE STEVENSON LLE 21166 Harm 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 4 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #23PI,PII,25,perME, ©863 1/17/07 Tifficate of Death Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Walton, Jr. Abraham Benford 11:50 A.M November 26, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laure 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 ☐ F 59 Yrs 578-58-5871 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Maryland Bowie Prince Georges Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20716 3010 Nutwood Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify. 4 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
U.S.Dept.Transportation Elementary/Secondary (0-12) College (1-4or 5+) Federal Highway Admin. 4 years Civil Engineer Technician other permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Item 27 is marked othe any injury or other treumatic event QMEs. 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be Abraham Benford Walton, Sr. Pearl Lillian Frazier 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3010 Nutwood Lane; Bowie, Maryland 20716 Patricia Mae Norris Walton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 24. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2006 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. Xa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sepsis; Secondary to Cellulitis of Genitals **Physician** week-/Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine PPROVED BY MEDICAL EXAMINER death certificate be executed burial-transit that initiated events resulting in death) Last the attending physicien and CERTIFICATION Due to (or as a consequence of) Physician/Medical IF FEMALE 950 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ě in the past 12 months? Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À Records, þ Paraplegia due to spinal cord tumor 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen Dehydration 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? certificate 1 ☐ Yes 2 X No Vital Physician: 25. Was case referred to medical examiner?

1 A Yes 2 No Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 50 this 28b. Time of Injury filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide hours Funeraf 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a, Certifier yletely 24 and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0024721 November 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 3 0 2006

an

Syed Akbar Sadiq, M.D.;14333 Laurel Bowie Road; Suite 208; Laurel, Maryland 20708

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year WILLIAM WILSON 9:20 NOVEMBER 20, 2006

Months

10f. Zip Code

1 ☐ Yes 2X No

Cab Driver

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln

20708

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

4b. City. Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Glen Burnie

Days

 \mathbf{P} M

9. Birthplace (State or Foreign

North Carolina

10d. Inside City Limits

Approximate Interval Between Onset and Death

Yes 2 No

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

20c. Location - City or Town, State

Brentwood MD

Private

USA

8. Date of Birth

18. Mother's Name (First, Middle, Maiden Surname)

Garnell Torrance

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

22. Name and Address of Facility Ft. Lincoln Funeral Home

3401 Brentwood Road, Brentwood, MD 20722

11/27/06

9010 Briarcroft Lane. #328 Laurel.MD 20708

3/23/30

Anne Arundel

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

PG

15. Decedent's Education (Specify only highest grade completed)

9010 Briarcroft Lane

1 Never Married Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

12th

Otho Wilson

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License

Jessie M. Wilson - Wife

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

5. Social Security Number

244-40-1646 Usual Residence of Decedent

10e. Street and Number

11. Marital Status

10a. State

MD

Director

Funeral

<u></u>

Completed

Be

ပ

Baltimore Washington Hospital Ctr.

6. Sex

1**X** M 2□ F

7. Age (In yrs. last birthday)

Laurel

12. Was Decedent Ever in U.S Armed Forces?

College (1-4or 5+)

n Yes 2 □ No f Yes, Give Year or Dates: **KOREAN**

10c. City. Town or Location

76

Funeral Director

with the Maryland 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death "natural", or the Medical than " permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, it

Baltimore, Maryland 21215-0036

Part1. rt1. Enter the disease, or comock, or heart failure. List only plications that caused the death. one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** CARDIAC ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy or in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I by Completed page 2 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🛣 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 ☐ Pending investigation Natural n 24 hours arter control the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical (Check only one) within 2.

To the F 29b. Signature and title of ertifie 29c. License number MD# 0101041579 NOVEMBER 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERGUSON, M.D. VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) State 32. Registrar's Signature NOV 3 0 2006 Registrar

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2. ♣No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State	,	Certific	cate of	Death			R	eg. No	20	06	1	1166
Physician		Registrar 1. Decedent's Name (First, Middle,Las	st)						Date of Dea Month	Day	Year	1	3. Time of	
edical Examin		Taveon J. Wats					1		Novembe	r 24,	2006 c County o		2012 h	nrs
7		4a Facility Name (if not institution, given Baltimore Washington Me				b. City, Town, or Glen Burnie	·				Anne Áru	undel		
Funeral	7	5. Social Security Number 6. S	ex 7. Age (In	n yrs. last bi		If Under 1 Yea Months Day			8. Date of Bi			Foreign		
Director		213-21-5004 1X	. M 2 F	1	. 8 Yrs	I I I I I I I I I I I I I I I I I I I	110010		July	5	1988	Cour	ntMary	/land
· A	F	Usual Residence of Decedent 10a State 10b County	110	c City, Tow	n or Locati	on							10d Inside	City Limits
0w all	,	Maryland Anne A		Glen									1 Yes	2 X No
ryland a-f sh	탾	10e. Street and Number				10f, Zip Code			1	10g. Cr	tizen of Wh	at Count	гу?	
th the Maryland 23a or 28a-f show any notified at once.	Director	481 Mainview C	t.			21061					USA			
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent. the Medical Examiner must be notified at once		11. Marital Status	12. Was Decedent Ev	er in U.S		s Decedent of His es, specify Cubar				0-	14. Race White		an Indian,	Black,
death or iten	uneral	1 X Never Married 2 Married	1 Yes 2 11	No		=			ican, ecc.)				ساس	
after ral", o	by F		If Yes, Give Year or Dates:	100		Yes 2 X No			rk done	16h	Specify: Kind of Bus	B1a		
hours	ed Fed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)	eted) 168		ost of working life				100	Killa of Bus	31116337111	adoli y	
11215-0036 tide within 72 dental Hygiene dental Hygiene warked other than "event, the Medical	Completed	11th	0		St	tudent				Н	igh S	Scho	001	
21215-0036 uld be filed within 72 Mental Hygiene marked other than to event, the Medical	녌	17. Father's Name (First, Middle, Last	i)			_			First, Middle,					
21; be fill ental F urked	<u>8</u>	Derek Watson							. Sand			. 04-4-	7 - 0 - 10	
e, MD 21215-0036 I and 2 should be filed within Health and Mental Hygiene iten 27 is narked other tha	H-T	19a. Informant's Name/Relationship (g Address (Stree Mainvie								51
e, MI	1	Longa N. Sanger 20a. Method of Disposition	a. Method of Disposition 20b. Place of Disposition (Name of cemetery,										own, State	
<u> </u>		1 X Burial 2 Cremation 3	12-1	1-06	c	rown	svi	lle,	Md.					
	ŀ	4 Donation 5 Other Specify 21 Signature of Funeral Service Lice	Sons	s Mor	tua	rv,	P.A		-					
Balti permit Departm Imports injury o	1	Janu & Room M	100483		8:	21 West	St.	Anr	napol:	is,	Md.	214	401	
Physician	\exists	23a. Part I Exter the disease, or comfailure. List only one cause on e		respiratory ar	rest, sł	nock, or hea	art	Between	nate Interval Onset and					
/Medical Examiner	1	Immediate Cause (Final disease	Gunshot Wound									- 2		eath
		or condition resulting in death)	Due to (or as a consequ	ience of):										
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of):										
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequ	ience of):						_		-		
ecuted and transit		events resulting in death) Last	1											
an al	edical	UNPENDED	AMENDED											
68760, certificate be exunding physician	ミ١	IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, outcome	of pregnanc			Fatan	0.0000000		2	3d Date of Month	-	ay	Year
OX 687 eath certifi	Physician	past 12 months?	1 Live birth 4 Pregnant at tin	ne of death		etal death 3 ther (Specify)	Ectopi	c pregnan	, cy		IVIONIN		uy	100
Box e death c the atten ed for us	ysi	1 Yes 2 No 9 Unknow	9 OHKHOWH							\perp				
P.O. E	by PI	Part II. Other significant conditions	contributing to death b	ut not result	ing in the	underlying cause	given in Pa	art I			o use contri			
S, P	ed t								24a Wa					igs available
cords, law requir	plet								auto		р			of cause of
Division of Vital Records, ra der death requires after death an Director. After this certificate has been set in by the funeral director, page 2 should be	Completed		-				15	101	1 Yes	2	No 1	✓ Yes	s 2	No
Vital Rec tysician: The this certificate	Be (25 Was case referred to medical examiner?	Hospital.	2 ✓ ER	/Outpatien		e of Death	<u> </u>	Home 5	Resid	dence 6	Other.		
of Ving Physical After this uneral di	: T 0	1 Yes 2 No 27. Manner of Death	28a Date of Injury	28	b. Time of		ury at Worl	k? [2	28d. Describe	how in				
on of ending Ph eath or: After the funeral	tion	1 Natural 5 Pending			DUND: 030 hrs	1	Yes 2	No S	Subject sh	ot				
/iSiC	fical	2 Accident Investigated Suicide 6 Could not	28e Place of Injur			et, factory, office	building, e	tc 2	28f Location or Town,		and Number	er or Rur	al Route N	lumber, City
Divi	Certification:	4 Momicide determin	ed (Specify) Loca		_				Elvaton Tow	ne Co				MD
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	Medical (29a Certifier 1 Certifying Physical Check only 2 Medical Examin	cian: To the best of my leer: On the basis of exami	nowledge, on and/o	death occu or investiga	irred at the time, o ation, in my opinio	date and pl in, death o	lace, and o	due to the car the time, dat	use(s) a e and p	and manner place, and d	as starte lue to the	ed e cause(s)	
To To com	Mec	29b Signature and title of certifier	and manner stated	<u> </u>		29c. Licen	se number			290	d. Date sign	ed (Mon	th, Day, Ye	ar)
		(1) and solo	2111D			O.C	.M.E.			No	ovember	25, 20	06	
		30. Name and address of person wh												
2			stant Medical Exar		11 Peni	n Street, Balt	ımore, N	/ID 2120)1					
St Regist	ate trar	IVIIV CI 67	32 Kegistrar's	Signature	do	with .								
DHMH 17 Rev 1/20	_			(RIGINA	AL.								

			For 1 - State Registrar	State of N	Marylan	-	artment of H <i>rtificate of L</i>		lental Hy	ygiene Reg. No.	06	40163
	Physici		Decedent's Name (First, Middle, La Barbara	st) Anne	Woj	ciecho	wski		2. Date of D Month Novemb	peath	2006	3. Time of Death 3:10 a. M
	/Medic Examir		4a. Fecility Name (If not institution, giv	e street and numbe				Location of Death			ity of Death	
			Joseph Richey Ho	spice			Baltimore					
	Funeral		5. Social Security Number 6. S	M 2□F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	av. Year)	9. Birtho	place (State or Foreign
	Director		207–34–0198 Usual Residence of Decedent	X	64	113.			April	5,1942	Penn	sylvania
	yland Now		10a. State 10b. County		10c. Cit	y, Town or L	ocation				1	0d. Inside City Limits
	h the Maryland or 28a-f ehow	ţċ	Virginia Fairfa	x	McL	ean						1 ☐ Yes 2 ☐ No
	or 28)lre	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	eth w	ral	6140 Ramshorn Dri				22101			United		
د	iteme	une	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13.	Was Decedent of Hi- If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or N Rican, etc.)		ace - Americ lack, White,	
7 29	within 72 hours after deeth with the Maryland ene. then "nature!", or iteme 23a or 28a-f ehow re Medicel Exeminer must be notified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give 2 Year or Date:	Ϋ́ X		1 ☐ Yes 2 ☐ No	Specify:		Spec	eify: Whi	te
40	2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occupa	ation		16b. Kind of		
515	hin 7. 9. "n Med	ple	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4c	or 5+)	life.	kind of work done d DO NOT use retired;	luring most of worki)	ing			
3.		S	12	5+		Opera	ations			C.I.	<i>A</i> .	
and	0 22 0	Be	17. Father's Name (First, Middle, Last,)				18. Mother's Name			ame)	
	should be nd Mental marked o	မ	Byrum Saam					Anne Fitz				
ん Mary	a 6 = 3		19a. Informant's Name/Relationship (Gene Wojciechowsk		/ Force	1	ng Address (Street a Ramshorn					The state of the s
00	s 1 end 2 if Health Item 27 i		20a. Method of Disposition	T (Husbe	20b. P	lace of Dispo	osition (Name of		Date	20c. Location		
altimor	permit. Pages 1 Department of It Importent: If ite any injury or ot		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from Sta	te C	emetery, cre	matory or other place	INOVAIL	•			
7	arthe ortan injur		21. Signature of Funeral per ice Lices		reu	-	an Crematory 2. Name and Addres	ZUL	6 nt Filmor			Virginia
Ba	Departiment Department	1	1 Drotoms	2	M0098		211 Lee High					ervice
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caus	ed the death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	for	1/1/24	onin-	1 Illet	h mez	3			Onset and Death
	/Medical		resulting in death)	a. Due to (or a	as a conseq	uence of):	4///	11/21				101110
	Examiner		Sequentially list conditions,	D								
	p it	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence of):						
	ecute and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or :	as a conseq	nence of):						
,09	licate be executed physicien and s the burial-transit					307100 017.						
68760,	ficate p phys	edical		d								
×	eath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			-			23d. D	ate of delive	nry
7 8	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	at time of de		□Ectopic pregnancy □ Other (specify)			N.	fonth	Day Year
15/ P.O.	t the d by the tached	hys	9 Unknown	9□ Unknown								
	The law requires thet the death certif ate has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions of	contributing to death	but not less	ulting in the u	inderlying cause give	n in Part I.	23e. Did	tobacco use co	ntribute to th	e cause of deat.
天 Fr	equir sen si ould		COUNTUR	110 01	DI	1000			1 🗆	Yes 2□No	3∕□ Prob	ably 4 Priknown
ECHON Records,	law r las be	Completed							24a. Was	DDSV	. Were auto	psy findings available inpletion of cause of
25 E	The cate has	S								ormed? 2 No	death? 1 🔲 Yes	
J.C.	ysician: is certific director.	Be	25. Was case referred to medical examiner?	Hospital:	_		Otho	26. Place of Death		-		14111
N C		5	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of Ir		ER/Outpaties 28b. Time of		4 🗆 INDISING HO		how injury occi		nospill
A ↓	ding Ph th. After th funeral	타	1 D atural 5 Pending 2 Accident investigation	(Month, I	Day Year)	Injury	Work	? res 2 □No	EUG. Describe	now injury occi	arred	/
Si isi	Attend r death octor: y	flca	3 Suicide 6 Could ≥ t b	e 28e. Place of	Injury - At he	me, farm, st	reet, factory, office		28f. Location	(Street and Nun	nber or Rura	I Route Number,
25 in	a afte	Certification;	4 Homicide det mined	building,	etc. (Specify	()			City or To	own, State)		
BARBAR	To the Hospital or Attuwithin 24 hours after de To the Funerel Direct completely filled in by the		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my kno	wledge, deat	h occurred at the tim	e, date and place, a	and due to the	cause(s) and r	nanner as st	ated.
18	the H in 24 the F	Medical	one)	and manner	stated.	tion and/or in	vestigation, in my op	innon, death decum	erd at the thire	, date and place	, and due to	The cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	1			29c. License	number		29d. Date sign	ed (Month, I	Day, Year)
			10/W/V/16	MIL		,	419	0/2	,	11/2	8/06	
	10		30. Name and address of person who	completed cause of	f death (Item	23a) (Type,	Print)	malt	Mai	1 5)0	10	
-	Sta	ato.	31. Date filed (Month, Day, Yeal)	32. Regi:	strar's Signa	ture	very no	20110	1111	1/4	1	
	Regist		NOV 2 9	2006	ر معود	B. A	med !	ĺ				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month NOVEMBER 26, 2006 **Physician** ELSYE HELEN WOYKE 07:23 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHESTER RIVER MANOR CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/15/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 132-03-6048 88 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD KENT CHESTERTOWN Director 10g. Citizen of What Country? 10e Street and Number 10f Zip Code 8718 PARK DRIVE 21620 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinat once. 1 Never Married 2 Married Specify: WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be EMMA KLEIN FREDERICK WOYKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IVA WOYKE/SISTER 8718 PARK DRIVE, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) NORTHPORT RURAL CEM. 11/29/2006 NORTHPORT, NY 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licenses Kick A Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bredst Cannow Metastatic 14 year **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and burial-trar Due to (or as a consequence of) Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. detached 9□ Unknown à signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be Arthritis: Spinal Stenosi 1 Yes 2 No 3 Probably 4 Unknown Be Completed peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 9ERDS 24a. Was an certificate has autopsy 28 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After fniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/27 50996 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print))e-1 Les te tour mo 21620 Stolder. MO 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		•	1 - State Registrar Amend #10e	State of M ££&19b Per	arylan FH (d / Depa G862 <i>Cel</i>	artment rtlficate	of H	ealth a H Death	and M	ental Hy	giene Reg. No.	00	6	40165
	Di vivi		1. Decedent's Name (First, Middle, La.	st)							2. Date of Dea			ear	3. Time of Death
	Physicia /Medic		DONALD	ADAMS							Decembe			06	4:10PM
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, To	own, or	Location o	f Death		4c.	County of	Death	
			GENESIS ELDERCARI					KV1					BALT		
	Funeral		5. Social Security Number 6. S	ex 7.Ag LageM 2□F		last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birt	h V. Year)	9	. Birthpl Coun	lace (State or Foreign try)
	Director		242-16-5078 Usual Residence of Decedent	A	95	115.					1-21-	-1911	L		NC NC
	and wo		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10	Od. Inside City Limits
	Many	jo	MD]	BALTIM	ORE								1 XYes 2 No
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	3e or	Ö	4803 TAMARIND RO	AD APT.3	02				21209	212	218	-	USA		
	s 1 and 2 should be filed within 72 hours after death with the Maryland Haalih and Menial Hygene. If mains and Menial Hygene. Item 27 is marked other than "neturel; or items 23e or 28e-f show other traumatic event, the Mudical Examinatings the Indifferd at	Funeral Director	11. Marital Status	12. Was Decedent		S. 13.	Was Decede	nt of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	.	14. Race -		
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8	rel',	i by	3 Widowed 4 Divorced	If Yes, Give 12 Year or Dates:			1□Yes 2Ū	74 140	Specify:				Specify:	BL	ACK
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Maryland	be fi	Be	17. Father's Name (First, Middle, Last,	,							(First, Middle,	Maiden	Sumame)		
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a N	12 sho	1	19a. Informant's Name/Relationship (/ Route Numbe		5 - 5		Code)
	is 1 and 2 of Haalth a item 27 Is other trai	3	VASHTI EDGE/GODDA 20a. Method of Disposition	AUGHTER	20b. P	1 / 1 J	3 E. 3		ST.		TIMORE,	20c Lo	cation - Ci		wn State
altimore,	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐		C	emetery, crer	matory or oth	er plac							
Ë	it. Part rtmer rtant njury		`4 □ Donation 5 □ Other (Specif		ARE	BUTUS N					22-2006		LTIM		
Ba	parmit. Pages Department of Important: If i eny injury or o		21. Signature of Funeral Service Licer	7	110		2. Name and			011					S F.H., INC
			23a. Party Enter the disease, or com	nlications that cause	d the death						BALTI		, MD	21	217 Approximate
8760,	death certificate be executed Examine an Medical and for use as the burial-transit death of the certification of	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enser underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence a	rence of):	ve h renal				re ency.				Onset and Death
.O. Box 68	ne death certif the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3□	Ectopic preg					2	3d. Date o		ry Day Year
<u>α</u>		by	Part II. Dther significant conditions of	contributing to death b	out not resu	ulting in the u	nderlying cau	use give	en in Part I.			bacco u		ite to the	e cause of death?
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<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	1		(Check only of				
ot	Phys this	٠ <u>۲</u>	1 Yes 2 No 27. Manner of Death	1 🗆 inpatie		ER/Outpatien 28b. Time of			4 V Nur		ne 5 Resid			Specify.)
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Division	I or Attendate death Director:	Certification:	4 Homicide determined	building, et	c. (Specify	y)	eet, lactory, t	onice			City or Tow			51 1 Idi (4)	nodio Nambor,
	Hospital	Medicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysicien: To the best niner: On the basis o and manner st	f examinal	wledge, death tion and/or inv	occurred at vestigation, in	t the tim	e, date and pinion, deat	d place, a	and due to the dead at the time, o	ause(s)	and mann place, and	er as sta due to	ated. the cause(s)
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	5		29b. Signature and title of certifier PMOTOGONI 30. Name and address of person who PRIYA JAGANNA	completed cause of c	leath (Item	23a) (Type,	Print). Char	1185	s st	reot	, Suit	e 4	202	,	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	4								
	Registr	-	DEC 1 8 2006	Esca	K	April	V								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. All Mr. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** THERESA M. ALEXANDER DEC. 08 2006 13:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1600 W. MT. ROYAL AV. APT. 1215 BALTIMORE CITY If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 TF Director 215-14-8525 85 11/19/1921 PENNSYLVANIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at XXYes 2 No MD N/ADirector BALTIMORE CITY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1600 W. MT. ROYAL AV, APT 1215 21217 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event the Machine Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 Wo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PEDIATRIC NURSE 12TH MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LESTER FREEMAN MATTIE E. MCQUAY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OWINGS MILLS, MD 21117 WORDSWORTH WY, UNIT HAWKINS / DAUGHTER 9401 LEONA 406 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 12/18/06 BALTIMORE CO., ARBUTUS MEM. PARK 4 Donation 5 Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funeral Service Licensee 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, Thier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fature. List only one cause on each line. Approximate Interval Between Onset and Death ate ause (Final **Physician** disea e condition result in death) /Medical Dusto (or as a consequence of) Examiner ROSC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PZ No 3 Probably 4 □Unknown 1 Yes Completed ASCULAR DISEA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☐ Yo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death
1 M Natural
2 Accident filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide determined To the Hospital within 24 hours al To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title o certifier 29c. License number 29d. Date signed (Month, Day, Year) npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co ATHEDRAL ST 32. Registrar's Signature (Cyear) State 16 Registrar

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. amend item 11,18 per mother 2866 4-11-07 vt. State of Maryland, Department of Health and Mental Hygiene Amend #20b Per FH G862 12/20/06 Jh. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Yeer Month **Physician** H (3202 DANIERIN 2128 ĭa 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner takoma Park 5. Social Security Number Hospital Montgomen Adventist If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 363-88-306 1 M 2 F 3 MIC Director Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No WindSon Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number KOCKFIELD Q 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: if item 27 ie marked other then Elementary/Secondary (0-12) A.A. DEGRA man a" 12th 18. Mother's Name (First, Nelda 17. Father's Name (First, Middle, Last) rst, Middle, Maid **a Jean** Dolinshek Ballere SR 19a. Informant's Name/Relationship (Type, Print) et and Number or Rural Route Number, City or Town, State, Zip Code) Bec Karen Ci 20a. Method of Disposition 20b. Place 12/21/06 Cheltenham, Md Chertenham Vetides Cem Burial 2 Cremation 3 Removal from State injury or Department in important: If eny injury or sonce. tem 22. Name and Address of Facility Juneral Service License FredHILTON march F. Home Bacto, md. 21229 for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, near failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Party. Ente shock or h Immediate Gause (Final disease di condition resulting in death) Amerschunc **Physician** Hecent alseaso /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the case has been signed by the case 2 should be detached by 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy perform /24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 0 To the Hospital or Attending Physician: 25. Was case referred to medicat examiner?
1 Yes 2 No the funeral director, Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manuer of Death 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sig ature and ti 42 who completed cause of death (Item 23a) (Type, Print) 10 w (and MUNGANG 32. Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 1 8 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2005

			1 - For State Registrar	State of Mary		artment of H				40168
			Decedent's Name (First, Middle, Last)			tinoate or i	Journ	2. Date of Dea		3. Time of Death
	Physici	-	Robert J. Behler	. Sr.				Month	Day Yea er 12, 200	r
3	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of I		4c. County of De	
			Ridgeway Manor N	ursing Home	2	Cator	nsville	e	Balti	more
	Funeral		Social Security Number 6. Sex	,	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birtl Min. (Month, Day		irthplace (State or Foreign Country)
	Director		309-01-2119	M 2□F 91	Yrs.		,100/3		18,1915 In	diana
	and *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryi 1 eho	ŏ	Maryland Baltimor							1 ☐ Yes 2 ☑ No
	the 128s	rect	10e. Street and Number		Catonsvi	10f. Zip Code			10g. Citizen of What	Country?
	3a or	Funeral Directo	313 Waveland Road				1228		USA	
	me 2	Jera	11. Marital Status	2. Was Decedent Ever	in U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)		nencan Indian,
9	after or ite	Ē	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ဩNo				Puerto Rican, etc.)		
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3	should ind Men ind marke	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (Street a		or Rural Route Number		, Zip Code)
Σ	and 2 saith a n 27 is		Arlene Lohrfink	Daughter	301 W	aveland R	oad: 0	atonsville	Marylan	1 21228
altimore,	of He of Her		20a. Method of Disposition 1 \(\overline{\text{\tint{\text{\tint{\text{\tint{\text{\tinx}\text{\tinx}\text{\texicl{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi}\text{\text{\text{\texi}\tex{\text{\texi}\text{\texi}\text{\text{\texi}\text{\text{\texi}\tex	2	0b. Place of Dispo	sition (Name of natory or other place	1	Date	20c. Location - City of	or Town, Stete
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Balt	permit. Pages Department of I Important: If it eny injury or o		21. Signature on Funeral Service License	· ///	22	. Name and Addres	s of Facility	Sterling A Catonsvil	shton Sch	wab Witzke
_	40 = a		(Miles	race		1630 Edmo	ndson	Avenue: Ca	tonsville	MD 21228
П			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	death. Do not ente	er the mode of dying	g, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between Onset and Death
7	Physician		tmmediate Cause (Final disease or condition resulting in death)	ass	cration	pull	none	1		48 hay
	/Medical Examiner			Due to (or as # co	nsequence of):	, due				14. St.
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	MCMM.	i Mala	N			1 mules
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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Box	leath certifica ettending pland for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr 1□Live birth 2□	Fetal death 3	Ectopic pregnancy			23d. Date of d Month	elivery Day Year
	The law requires thet the death certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5 □	Other (specify)			Working	Day Teal
O. 0.	ires thet the de signed by the e I be detached t	Ph.	Part II, Other significant conditions conf	tributing to death but no	t resulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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S	w require been si should b	lete						24a. Was a	n 24h Were	autopsy findings available
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ta		0	25. Was case referred to medical				26 Place M	1 ☐ Yes :		s 2 No
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0	Attending Physician: r death. ector: Atter this certification in the funeral director.		27. Mann of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury Work			ow injury occurred	
<u>S</u>	tendi eath. for: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				es 2□No			
Division of Vital Records,	in Party of	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre pecify)	et, factory, office		28f. Location (Si City or Town	reet and Number or F n, State)	Rural Route Number,
_	e Hospital 124 hours e e Funeral I letely filled		29a. Certifier 1 Certifying Phys	ician: To the best of my	knowledge doesn	occurred at the time	e date and -	place and due to the -	auco(c) and a	as stated
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	(Check only 2 Medical Examin	er: On the basis of examined manner stated.	mination and/or inv	estigation, in my op	inion, death	occurred at the time, d	ate and place, and du	ie to the cause(s)
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)	~		Dames 3	Birchest	in	00	2114		12/13/06	
	12 1		30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type, I		, , ,	BLACKES	S My	
	U i		5411 OLD FREDER	ECK 20,50	127E(8,	BALTANO	RE M.	0-0/22	7	
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	Sta Registr		31. Date filed (Month Day Year) 8 20	32. Régistrar's S	Signature	carte	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 00 A 06 4c. Counfy of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NA Baltimore Bon Secour Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number Days Hours 1 M 2 □ F 9-25-1951 216-56-6452 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State 1X Yes 2 No Baltimore NA Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21213 1338 N. Chester Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indien. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Black Specify: Specify 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rogers Mae Addie Bishop Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2924 Limond Place, Baltimore, Md. Sister Gloria Hunter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12-16-06 Dundalk, Md. Mt. Carmel Cem. 4 Donation 5 Other (Specify) March F.H. East 22. Name and Address of Facility 21. Signature of Funeral Service License 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WK disease or condition resulting in death) as a consequence of): raubclominal Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4∐Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VVDOSLS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mmune deficienc 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed: 'as 2X No 2 □ No umon 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3□ DOA 1 Inpatient 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Iniury 5 Pending investigation 1 ANatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide

the burial-transit physician for use as signed by the a ate has page 2 s certificate or Attending Physician; this To the cours after death.

To the Funeral Director: Aft

The law requires that the death certificate be executed

Box 68760,

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Division or Vital Records,

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Physician /Medical

Examiner

Funeral

Director

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an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

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Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other transment.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Physician/Medical Examiner Completed by Be မ Certification: 29a. Certifier

Medical

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many®etated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

on who completed cause of death (Item 23a) (Type, Print) Bon Secours HOSP:
MEKA UFONADU, MD. 2000 W. Baltimore St. Baltimore MD 21223 CHUKWUEMEKA

State Registrar 31. Date filed (Month, Day, Year)

4 ☐ Homicide

2006

determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 16, 2006 **Physician** 11:35 A M Robert William Bluehdorn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth (Month, Day, May 9, f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X** M 2 □ F May 577-52-5025 71 Washington, DC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland | Montgomery Bethesda 1 ☐Yes 2 No Director 10e. Street and Number 5201 Glenwood Road 10g. Citizen of What Country? 10f. Zip Code 20814 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must I once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2□No If Yes, Give Year or Dates Korea 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RAC LOGICON Research Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Reinhold Bluehdorn Elizabeth Fultz ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christa P. Bluehdorn/Wife 5201 Glenwood Road, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition December 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Montgomery Crematorium 18, 2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses Chaple M00092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) theroscianon c CAMDIO WASCU **Physician** Mensy /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: ase If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year should be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Mnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 1 Yes 2 1 Inpatient 2DER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral dir 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural s after dec... 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral 6

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIT me 8600 31. Date filed (Month, Day, Year) DEC 2006 8

29b. Signature and title of certifier

6001657WW 327 Registrar's Signature

aD

29c. License number

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29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Francis Bond /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner Kosedale timasc ranklin anare If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) tf Under 1 Year Date of Birth (Month, Day, 5 Social Security Number **Funeral** Months Days Hours Yearl 1☐M 2☐F 94 Yrs. Director 212-01-5164 Feb. 9 1912 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. tnside City Limits 10a. State 28a-f ehow notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore White Marsh 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ō other traumatic event, the Medical Examiner must be 8100 Rossville Boulevard Apt. 321 21236 U.S.A. Ітете 23а death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. 'ie marked other then "naturel", or Ite 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) NA Cooper Seagrams Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Bond Blanche Eldridge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 ie m any injury or other traum once. 9505 Kingscroft Terrace Unit-R. Perry Hall, Md. William J. Bond (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State December 4 Donation 5 Dother (Specify) Entombment Oak Lawn 20, 2006 East Point, Maryland 22. Name and Address of Facil 21. Signature of Funeral Service Licensee Dabrowski/Chojnacki Funeral Homes P 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Pan1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cardiac all each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) certificete hes been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 000 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor 1 ☐ Yes 2 ☐ No 1□ Yes : After this certifice e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation efter death.
Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours e Hospitai To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

Baitmore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Dr. Catherine

31. Date filed (Mon

9000

32 Registrar's Signature

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nna,	Maryl d 2 shout th and Me 7 10 mart	traumatic	19	e. Informant's N		ship <i>(Type, Print)</i>				-				A Route Numbe						
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	To the within 2	comp	29	b. Signature and	title of certific		20-			290	License	201	77			_ /	1	Day, Year)	P	
	1		30). Nam, nd add	tress of person	who comp et d	cause of de	ayn (Item	23а) (Туре	Printy	11	176) []]	Belve	10	/	7	1710		
	Re	State gistra		Date filed (Mor	B. (2)	8 2006	32. Registrar	's Signa	ture	are some		77	W	PUUT	OU	4	1	413		

06-09081 David Brewer

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar . Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day November 29, 2006 **Medical Examiner** 0629 hrs David Brewer 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Johns Hopkins Hospital 5. Social Security Number 7. Age (In yrs, last birthday If Under 1 Year | If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9 Birthplace (State or **Funeral** Months Days Hours Director Country) Maryland 212-76-4450 1 XM 2 F 48 July 9, 1958 Usual Residence of Deceden IOc. City, Town or Location 10d Inside City Limits X Yes 2 No 28a-f show MD Baltimore death with the Maryland 10e. Street and Number 10f. Zip Code s 23a or 28a-f e notified at o 10g Citizen of What Country 3701 Milford Avenue 21207 USA 13 Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes f Yes, Give Year Widowed Divorced Specify black 1 Yes 2 X No specify. 'natural", ð or Dates 15 Decedent's Education (Specify only highest grade completed) Decedent's Usual Dccupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 nem of Health and Mental Hygiene ant: If item 27 is marked other than "or other traumatic event, the Medical I Baltimore, MD 21215-0036 unk disaabled none 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Richard Brewer <u>ALberta Cauthorne</u> 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Brewer/brother Milford Avenue Baltimore, MD 21207 sition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State rtant: Donation 5 X Other Specify. Funeral Service ROHald Name and Address of Facilit Signa 22 Name and Address of Facility
State Anatomy Board
Baltimore, MD 2120 655 W. Baltimore Street Baltimore, Anter the disease, or complication that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** dist only one cause on each line /Medical Death Complications of seizure disorder Immediate Calise (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examiner cause. Either Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and ca X UNPENDED AMENDED #23a,27,28a-f, perME, g863, 1/22/07 TT Box 68760, 23c If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? After this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medica 26 Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 2 1 V Yes 28a Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 Yes 2 X No unk unk. 2 unk. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f Location (Street and Number or Rural Route Number, City or Town, State). 954 Forrest St. 3 6 X Could not be

Division of Vital Records, P.O. Hospital or Attending Physician: To the

determined Correctional Facility Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

O.C.M.E.

November 29, 2006

and manner stated 29b. Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31 Date filed (Month, Day) State 6 Registrar

hues

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year, 00 **Physician** .006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner REHABS EXTENDE TOKE If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Days 9661 -del marisland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director ma. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 3504 or Itama 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Item any Injury or other treumatic event, the Nedical Exami 1 DYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced 1956 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltmore College (1-4or 5+) Elementary/Secondary (0-12) Authority worker 12th NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be per wesles 00 lohn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick Saeto, md, 2,1229 WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12/14/06 remalor 5 ☐ Other (Specify) Metro 4 Donation 22. Name and Address J Facility 21. Signature of uneral Service License Balto, nd, 21229 march runeral Home 23a. Part. Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Tyes To the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of I	Maryland / Del	partment o				giene Reg. No.	006	0	75	
н	Physici	an	1. Decedent's Name (First, Middle, L.	ast)		2. Date of Dea Month	Date of Death Month Day Ye			Death				
	/Medic		SAMUEL RICHARD CREE			1 # 0% T		15	DECEMBER		2006	1812	Р М	
	Examin	er	4a. Facility Name (If not institution, gi		91)		n, or Location	of Death			ounty of Death			
	Funeral			Sex 7.	Age (In yrs. last birthda		ear If Under	r 24 Hrs.	8. Date of Birt	h	NE ARUNDI 9. Birth	place (State o intry)	r Foreign	
	Funeral Director		211-34-0670	1□ M 2□ F XX	64 Yrs.	Months Da	ys Hours	Min.	JUNE 1,		Col	PA		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, Ite Madical Examinational be notified at any once.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside Ci	ty Limite	
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		Director	10e. Street and Number	.RY	KENSINCTON	10f. Zip Cod	ie			10g. Citize	n of What Cou		_ XX	
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		Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et							
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force Y Yes 2 If Yes, Give	□No		1 ☐ Yes 2 XXNo Specify:				pecify:			
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Maryland 21215-0036		ပ	FDIFIN CREF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
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re,	s 1 ar f Hea itam other		20a. Method of Disposition		20b. Place of Dis		f - !		Date	20c. Loca	tion - City or T	own, State		
altimore,	Pages nent of ant: If its ary or o		1 ☐ Burial 2XX Cremation 3X 1 ☐ Donation 5 ☐ Other (Spec		ite .	REMATORY I		12.14	.2006	BALTI	MORE, MD			
3alt	epartr pports ny inju		21. Signature of Usuneral Survice Lice	(Se)		22. Name and Ad								
8	Physician /Medical Examiner		FINK FUNERAL HOME, P.A. K CRECORY KINK MO1148 426 CRAIN HWY SW CLEN BURNIE, MD 21061											
			23a. Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death											
			disease or condition resulting in death)	a5	EPTIC S	SHOCK								
			Due to (or as a consequence of): PER ITON ITIS											
	D ==	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undery, ing Cause (Disease or injury	Due to (or	as a consequence of):	0.0								
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Box	h certi ending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		3 □Ectopic pregnancy					23d. Date of delivery			
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Ĕ			27. Manner of Death Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Injury at Work? Accident 3 Suicide 6 Could not be determined determined 28b. Place of Injury - At home, farm, street, factory, office 28f. Location (Street at the street) 28b. Time of Injury at Work? M							ow injury	jury occurred			
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	To To I	Σ	29b. Signature and title of certifier 29c. License number 29d. D						29d. Date :	Date signed (Month, Day, Year)				
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5	9		30. Name and address of person with	Completed cause		e, Print) MD .FAC.	3	01	medi apolis	ma	1 3 1.	101		
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	Regist	rar	NED TO C	000	and so led									

		•	For State Registrar	State of Ma	aryland / [artment of F tificate of			ental Hy	giene Reg. No.	200	6	4017	6
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	CHM	IELE	W	skí		2	Date of De	ath Day	20	(ear	3. Time of Deat 1838	
>	Examin										ace (State or For	reion			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-1 ehow as any injury or other traumatic event, the Medical Examiner must be notified at one.														
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		Director	Maryland Baltimore Dundalk								40 000		1 ☐ Yes 2 📉	INO	
		i Dir	10e. Street and Number 7236 Conley Street		10f. Zip Code 21224						rug. Citi	zen of Wh US <i>P</i>		.ry r	
		Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		13.			Origin? (Speci	ty Yes or No	0-	14. Race - American Indian, Black, White, etc.			
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nd		Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name									Sumame)			
Maryland		P	Benjamin Chmielewski Bertha C. Bujnowski												
			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7236 Conley Street, Dundalk, Maryland 21224												
Baltimore,			20a. Method of Disposition 1 Disposition 2 Cremation 3 4 Donation 5 Other (Specify)				sition (Name of natory or other pla Cemtery	сө)	December 18, 20			cation - C dalk,	•	wn, State Yland	
Balt			21. Signifure of Fyrieral Service Licen-	ome	lly	7	Name and Address Onnelly 110 Soll	ers I	Point I	Road,	Dund	alk,E alk,N	P.A. 1D. 2	21222	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed by Law Minn 24 hours efter death. To the Funarel Director: After this certificate has been signed by the attending physicien and position of the funarel Director. After this certificate has been signed by the attending physicien and position of the funeral director, page 2 should be detached for use as the burial-transit position.		23a. Part 1. Enter the disease or complications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between												
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			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1												
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rds, P		þ									Did tobacco use contribute to the cause of death				•
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Vita		Be	examiner? 1 Yes 2 No							h (Check only one)					
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			To warma and accress of person who of	ompleted cause of d	eath (Item 23a)	- (Tyne	Print)	120	, 57	-	DE	C 1	5, C	2006	
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	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 8 2006	32. Registra	ar's Signature	all.	p.								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend item#2, perMD, g862, 12/18/06 Pertificate of Death 2. Date of Death 11/26/2006 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nur 4c. County of Death Examiner 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Davs Director 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e Street and Number 10g. Citizen of What Country? 12 AURNI COOK by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. filed within 72 hours after of Hygiene. 1 Never Married 2 Married 1 ☐ Yes 💥 No 3altimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired d 2 should be filed within 7 th and Mental Hygiene. **7 is marked other than "**' College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should ပ other traumatic 19a. Informant's Name/Relationshil (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) of Health a thod of Disposition 20b ě 1 Burial 2 ☐ Cremation 3 Removal from State Important; any Injury o 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of such shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Canc **Physician** Vear /Medical Due to (or as a conse unce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 □ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of ate has page 2 s autopsy perform death? 1 ☐ Yes 2 ☐ No certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Accident 1 Tes 2 □ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 505 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333 en more 31. Date filed (Mo. th, Day, State

DHMH 17 Rev 1/2001

Registrar

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or Iteme the Medical Examinar Baltimore, Maryland 21215-0036 "natural" than Hygiene.

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene
Amend #28f, perME, g862, 12/27/06 TT Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yee **Physician** 22:45 PM December (2, 2006 Rita A. Doxzon /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Balthmore Baltimore Sinai Hospital 04 If Under 1 Year If Under 24 Hrs. Min. Months, Days Hours Min. Oct. 2, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M **2**CXF 214-14-5004 84 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore Catonsville 10f Zip Code 10g, Citizen of What Country? 10e. Street and Number 2307 Old Frederick Road 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Engineering permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Important: If Item 27 Ie marked other th eny injury or other traumatic event, IIIa QDCs. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Paul J. Mueller Hilda Bode ပ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4450 Bark Hill Road; Union Bridge, MD 21791 Kent Doxzon Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12-16-2006 Baltimore, Maryland

22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundinal Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Res Failure piratory /Medical Due to (or as a consequence of): Examiner Closed Head Injury Subdural Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ing and Due to (or as a consequence of): Edward Hart no By Examine physicien and s the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ✓ Yes 2 ☐ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗷 No Fall in hursing home death. 11-27-06 unknown Director: 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number of Rural Route Number City or Town, State) 50/ High Acre Rd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. home within 24 hours e To the Funeral (29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 1006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 10751 talls 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 8 Registrar The spend

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DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

DEC

2006

32. Registrar's Signature

Estisted.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** December 12 2006 SOPHIE Κ. DAVIDSON 4:36 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE ROLAND PARK PLACE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 05/16/1910 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 21/2 F Months Days Hours 96 Yrs. NY 215-24-3586 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Ves 2 □ No Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #817 21211 USA 830 W. 40TH STREET Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify: Š 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) JEWISH FAMILY SERVICES SOCIAL WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be YELLIN KILLIAN MORRIS **ESTHER** ္ဌ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 10 CHARLES STREET #1 - MONTPELIER, VT 05602 DEBORAH MESSING / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 12/15/06 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) FIBVILLATION ATVIAL Examiner Due to (or as a consequence of) Physician/Medicai Examiner been signed by the attending physician and should be detached for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 1 ☐ Yas 2 X No 3 ☐ Probably 4 ☐ Unknown anticong want þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed OSTEU porosis certificate has page 2 HYPERTLUSION 1 ☐ Yes 📜 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Hospital or A: 24 hours after 4 T Homicide 24 hours edical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35102 DecemBER 17, 2006 Um mo lawy Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 WEST 40Th street Balfimore marylang 21211 HILAM Don 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2006 Registrar

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December 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard E. Fisher 1600 Crain Hwy. S. Glen Burnie, MD 21061 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		spital ours ours neral filled		29a. Certifier 1 → Certifying Ph	ysician: To the be	est of my knowledge, de	ath occurred at the time	ne, date and	place, and due to the	cause(s) and manner a	s stated.
December 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard E. Fisher 1600 Crain Hwy. S. Glen Burnie, MD 21061 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		ns Ho n 24 h ne Fui	dic	(Check only 2 Medical Exam	iner-On the basi	s of examination and/or	investigation, in my o	pinion, death	n occurred at the time,	date and place, and du	e to the cause(s)
December 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard E. Fisher 1600 Crain Hwy. S. Glen Burnie, MD 21061 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the within To the comp	W	29b. Signature and title of certifier	0)			~ . 5	29d. Date signed (Mon	th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard E. Fisher 1600 Crain Hwy. S. Glen Burnie, MD 21061 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		do			1		I	106	>17	December 1	8, 2006
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	, \									
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registral DLO I O 2000 Killediae All Comments		Sta Registr					Charles &				

			For Stata Ragistrar	State of Ma	ryland /		artmen <i>rtificate</i>			id Mei		giene Reg. No.	006	40	83
	Div. etc.		1. Decedent's Name (First, Middle, La	st)						2.	Date of De.	ath Day	Year	3. Time	of Death
	Physicia /Medic		Annie Viola E	ppley						De	eC.	17	2006	5:3	35a ™
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of E	Death		4c. (County of Dea	th	
			Lorein Nursing	& Rehab.	Cent	er	Tane						Carrol	1	
	Funeral Director		5. Social Security Number 6. S 214-28-5448	ex 7. Age □ M 2∏ F 9.8	(In yrs. last b	rthday) Yrs.	If Under Months	1 Year Days		Min.	Date of Bird (Month, Da July	y, Year)	C	thplace (State ountry) enn•	e or Foreign
	pu 🛾	ŀ	Usual Residence of Decedent 10a, State 10b, County		10c. City, Tov	vn or Lo	eation		-					10d. Inside	City Limits
	sho	5	Maryland Carrol	-			ches	+ 0 10							s 2 No
	the N	Director	10e, Street and Number	1		riai.	10f. Zip					10a Citiz	en of What Co		
	with a or						TOI. ZIP	0000	21102				5 • A •	ountry :	
	ns 23	era	3281 York St.	12. Was Decedent E	ver in U.S.	13.1	Was Deced	ent of Hi	21102 spanic Origin	? (Specif	v Yes or No	- 1	4. Race - Ame	erican Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examilier must be multiped at once.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	fYes, spec 1 □ Yes 2	ify Cuba	n, Mexican, P Specify:	Puèrto Ric	an, etc.)		Black, White Specify:	e, etc. Whit∈	2
Ö	2 hou	ted	15. Decedent's Ed	ducation	168	. Dece	dent's Usua	I Occupa	ation			16b. Kin	d of Business		
21215-0036	within 73 ene. than "ne	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+			kind of wor DONOT us S∈Wif		during most of)	f working		Н	omemak	er	
q 2	filed Hygi other ent, I	ပိ	17. Father's Name (First, Middle, Last,				, C W 1 1		18. Mother's	Name (F	irst, Middle,				
lan	ld be lental ked d ic ev	To Be	Harry R. Mille	r					Jen	nie	M. W	ilda	asin		
Maryland	shou nd M mar	-	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailir	ng Address	(Street a					Town, State,	Zip Code)	
ž	alth a alth a 27 is		Cindy Ganjon -	daughter	1	432	Hug	hes	Shop	Rd.	. Wes	tmir	nster.	Md.	21158
ore,	of He of He item		20a. Method of Disposition		20b. Place	of Dispo	sition (Nan	ne of ther place	θ)	Date	•	20c. Loc	ation - City or	Town, State	
Ē	Page nent c		1 ⊠ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		New L	uth	eran	Ce	m. De	c. 2	20,20	06 1	Manche	ster,	Md.
Baltimore,	permit. Departr Importe any inji		21. Signature of Funeral Service Licer	see X					ss of Facility Funer				l Dr.M	lanche	ester
			23a. Paw. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do			-						Approxim Interval B	
4	Physician		Immediate Cause (Final disease or condition	3110 0000 311 00311 IIII		F	new	mo	210					Onset an	d Death
	/Medical		resulting in death)	Due to (or as a	consequence	_			4.1					V	
	Examiner	_	Sequentially list conditions,	b		-0									
_	ed sit	nine	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	or):									
2D-	xecut and	Examin	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):									
,8260,	cate be executed physician and the burial-transit	dical		d											
687		0 1		0.											
.O. Box	le death certifii the attending I hed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal deat		Ectopic pro			_		2.	3d. Date of de Month	livery Day	Year
Φ.	res that the de igned by the a be detached f	Ph	Part II. Dthar significant conditions of	ontributing to death but	not resulting	in the u	nderlying ca	ause give	en in Part J.		23e. Did to	obacco us	se centribute to	the cause o	f death?
Records,	law requires that the as been signed by th 2 should be detache	ted by									1 🗆 🗅	res 21	No 3□P	obably 4 [Unknown
ecc	e taw ru has be ye 2 sh	Completed								_	24a. Was autop	sy	24b. Were at	topsy finding	
	Th ate pag	Con									perfo	rmee? 2 ☐ No	death? 1 ☐ Yes	2 □ No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11 2.1					26. Place of	Death (C	heck only o	ne)			
of/	Physi this c	၉	1 Yes 2 No	Hospital: 1 Inpatien		-		- CONTROL (1997)	4 Nursii	-			Other (Spe	cify)	
nc 0	g	ion	27. Manual of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		Time of Injury	M 2	8c. Injury Work	rat ⟨? Yes 2		I. Describe t	now injury	occurred		
islo	ten Jeat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be		y - At home f	arm etr			163 2 110		Location /	Street and	Number or R	iral Boute Ni	m her
Division	in the	Certification:	4 Homicide determined	building, etc.	(Specify)	aiii, sa	cot, ractory	, once			City or Tov		174111007 07 711	3/4/ / 10010 / 4	a 11201,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier 11 Certifying Pt (Check only one)	ysician: To the best of niner: On the basis of and manner state	examination a	e, deat nd/or in	n occurred vestigation,	at the tim	ne, date and pointion, death o	olace, and	I due to the at the time,	cause(s) a	and manner as place, and due	s stated. to the cause	ə(s)
	o the	Me	29b. Signature and title of certifier		-		29c	. License	number			29d. Date	signed (Mont	h, Dey, Year))
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	12		John (Anel M	completed cause of de	anor A	2.	50	je 3	307 V	-05}	mins	per	MO	2115	7 ·
	Sta Registr		31. Date filed (Month, Day, Year)	006 32 Registra	's Signature	19	and)	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 0428 GERTRUDE ELGIN Veember 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more 15a N/A Balhmore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 0472771917 1 □ M 2 🔽 F 213-05-9482 89 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits !/ Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director BALTIMORE OWINGS MILLS 1 ☐ Yes 2 📉 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21117 8 REGALIA COURT #C Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. WHITE 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Mag College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORWITZ SCHILLER ROSE ALBERT ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 REGALIA COURT #C - OWINGS MILLS, MD 21117 GEORGE ELGIN / HUSBAND altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHAAREI ZION CEMETERY 12/14/2006 ROSEDALE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Lic SOL LEVINSON & BROS., INC. <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u> 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) **Physician** morning /Medical Due to (or as a conse , u nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. End of carry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? /es 2 No 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: P 1 Yes 1 ☑ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After completely filled in by the funera 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ES 000 13, 2006

0 State Registrar

MP 124 ulia 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Ethel V. Felder 2006 12 0057 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 ☐ M 2 🙀 F Yrs 217-28-7865 Director 2-9-1931 Md Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, th∞ Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Director MO NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5918 Cedonia Ave. 21206 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Ininportant: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines ones. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: þ Black 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) J.H.H. Excort Massagner UNKN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jefferson Vicotia James ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 5918 Cedonia Ave., Baltimore, Md. Ann Stewart 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cem. 12-19-06 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nonths Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ worathy end 3 Probably 4 □Unknown 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ? 2 No Other: 4 Nursing Home 5 Residence 6 DOther (Specify) NOSP (Hospital: 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medical 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St-Barnno no Chances W 6565

State Registrar

4 ☐ Homicide

29a. Certifier

32 Registrar's Signature 31. Date filed (Month, Day, Year) **DEC 18** 2006

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Fischer Mary 12 05 10:15PM 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Holly Hill Manor, 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🗷 F Yrs 82 2/05/1924 ΜĎ 220-74-5298 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ Yes 2 X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 531 Stevenson Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 M No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone REpair 5th communications 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Fischer Gertrude Mary Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 531 Stevenson Lane Towson, MD 21286 Holly Hill Manor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Ser ice Licensee Ronal S Wad ²². Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDIOUASCULAR Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner Physiclan/Medical Examiner

signed by the ettending physician and the detached for use as the burial-transit

page 2 should

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s after death.

I Director: After this of in by the funeral di

within 24 hours a

To the Funeral D

completely filled

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Completed

Be

Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

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Completed

Be

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examinations to control once.

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2X No

2	6. Place of Death (Ci	heck only one)	
r:	4 ☑ Nursing Home	5 Residence	6 ☐Other (Specify)

25.	Was case examiner?	referre	d to medical
	1 ☐ Yes	2 X No	
27.	Manner of	Death	
	1 X Natura	ı	5 Pending

investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes

3□ DOA

28d. Describe how injury occurred 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check of
	one)

2 Accident

3 Suicide

4 Homicide

Leave Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certiti

29c. License number 17041 29d. Date signed (Month, Day, Year) ECEMBER 2006

30. Name and address who completed cause of death (Item 23a) (Type, Print)

MARC I. LEAVEY 31. Date filed (Month, Day, Year)

YORK 1205 32. Pegistrar's Signature

LUTHERVILLE MY 21093

State Registrar



DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Day Physician Griffin Joeann 06 2006 9:52 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 6225 York Road 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12–3–1942 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min 219-40-5641 1 M 200 Director S.C. 64 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits Baltimore 1 TXYes 2 □ No Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21212 6225 York Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elizabeth Coney Agency Nurse's Asst llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Townes Jackson Arlene Robert ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Glenmore Ave., Baltimore, Md. 21214 Steven Jackson Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-13-06 Randallstown, Md. King Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Millan 1101 E. North Ave., Baltimore, Md. 21202 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) EYONTRS /Medical Examiner Due to (or as a consequence of): month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner executed that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician The law requires that the death certificate be IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 TYes AQ/No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After (Month, Day Year) Natural 2 Accident 5 Pending investigation s after death. 1 TYes 2 TNo 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled in by 4 ☐ Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in the cause of 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year)

∠| State

Registrar
DHMH 17 Rev 1/2001

Johns Hoplyns

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

DEC 18

RES-000

DECEMBER 12Th, 2006

Hospital, 600 Purth Walte Steet, Rollmore Manyland

06-09204 David Goetz Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Month Day December 3, 2006 1840 hrs Medical Examiner David Goetz 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Shady grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or 7, Age (In yrs. last birthday) **Funeral** Foreign Puerto Months Davs Hours Director Mar 7, 1958 216-78-7217 1 XM 2 48 Rico Usual Residence of Decedent 'n 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 X No 28a-f show MD Montgomery Gaithersburg Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director r items 23a or 28a-f nust be notified at o 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 19018 Mills Choice Road #2 20782 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 12, Was Decedent Ever in U.S. 14. Race - American Indian, 8lack, must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces 1 X Never Married 2 X No Yes white If Yes, Give Year Widowed Divorced 4 1 X Yes 2 No specify: Puerto Rican Specify Examiner 3 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+ marked other than ' Baltimore, MD 21215-0036 6 0 laborer construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Goetz Sr Alda Gotay ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alda Santiago/mother 19556 Crystal Rock Drive Germantown. MD 20874 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State t: If it crematory or other place) Burial 2 Cremation 3 Removal from State permit Page Department o Important: I Donation 5 X Other Specify 21. Signature of Funeral Service Licensee Ronald S. W. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 1222 I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** e. List only one cause on each line. /Medical Death Cause (Final disease End stage renal disease Examiner or condition sulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed d and Physician/Medical YUNPENDED AMENDED #23a, PII,27, perME, g862, 12/21/06 TT Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Cocaine use Completed 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of has performed? death? To the Hospital or Attending Physician: The ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be Other₄ examiner? 2 Z ER/Outpatient 3 DOA Nursing Home 5 Inpatient Residence 6 Other 1 🗸 Yes ٩ 2 No 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury After 27. Manner of Death 28c. Injury at Work? 28d Describe how injury occurred XNatural Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined within 24 hours a 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 4, 2006 LMa. 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month 32. Registrar's Signature Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOWARD 2006 County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMOIZE LOHNS HOPKINS BAYVIEW MED CENTER BALTIMORE CITY If Under 1 Year If Under 24 H/s. 8. Date of Birth Min. (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Year) 214-98-468 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No md. 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WORKER 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howar 1eresA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) linton St. Balto. mather eresa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 3 ☐ Other (Specify) 18/06 21. Signature of Juneral Service License Funeral Home march 23a. Part. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi ne cause (Final diseas- cr condition resulting in death) SEPSIS Due to (or as a consequence of): BRONCHOPLENAZ FISTULA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) NUMONIA Due to (or as a consequence of). AID 5 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□Ho 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

burial-P.O. Box 68760, Division or Vital Records, certificate Hospital or Attending n 24 hours after death.

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Physician/Medical Completed by Be ဥ Certification: Medical

Examiner

Physician

/Medical

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Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

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Pages 1 and
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Department o Important: If any Injury or

Physician /Medical

Examiner

filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

1 Natural 5 Pending investigation 2 Accident

29a. Certifier

6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

29c. License number 5-001

29d. Date signed (Month, Day, Year) DECEMBER 9, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE, BALTIMORE, MD ROBERT DUTUMEY

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature



DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere 0.0.0

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O	ding Ph th. : After th s funeral	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	y Year) Injury	Worl	k? Yes 2 □No		on injury observed	
Division	Attending ir death. ector; After by the fune	ifica	3 Suicide 6 Could not	286. Place of Inj	ury - At home, farm, s	street, factory, office		28f. Location (St	treet and Number or F	Rural Route Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the incompletely filled		(Check only 2 Medical Exa	hysician: To the best miner: On the basis of	f examination and/or	ath occurred at the tir.	e data and place pinion, death occur	and due to the cored at the time. d	auea(s) and manner s ate and place, and di	e to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** nomas 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** Months Year) 1 X M 2 ☐ F Yrs 577-86-8863 48 Director August 7, 1958 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1⊠Yes 2 No Rockville Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 729 Beall Avenue 20850 United States items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Lab Assistant Medical Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald A. Hurst Carol McIntosh 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna H. Eaton/Sister 10029 Dellcastle Road, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State December 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 18, 2006 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia resulting in death) /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No. 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 autopsy performed? Yes 20 No 1□ Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: S/No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Certification: 1 🗷 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours after To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rocking, MB 20850 Brian CARPENTER Center 99101 Medicul 32 Registrar's Signature 31. Date filed (Month, Day, Year. State DEC Registrar 8 2006

06-09433 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Susan Patricia Hubbard 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0130 hrs December 11, 2006 Medical Examiner Susan Molloy Hubbard 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 8016 Grand Teton Drive Potomac 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Months Days Hours Director Country) 040-42-1040 60 23. 1946 M 2∑ F Yrs Aug. Usual Residence of Decedent 10d. Inside City Limits II V 10b County 10c City, Town or Location 1 Yes 2 X No 28a-f show Maryland Montgomery Potomac hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country at 8016 Grand Teton Drive 20854 United States items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married 1 X Yes 4 X Divorced 1 Yes 2 X No specify. Widowed Yes, Give Year 1979–2002 Specify White traumatic event, the Medical Examine ۾ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene ant: If item 27 is marked other than "nor other traumatic event, the Medical E timore, MD 21215-0036 5+ Nurse <u>Health Care</u> 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Bolan Molloy, Helen Wand 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. Smith/Domestic Partner 8016 Grand Teton Drive, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Montgomery December 1 Burial 2 X Cremation 3 Removal from State ment 16, 2006 Bethesda, Maryland 4 Donation 5 Other Specify Cremătorium. Inc. ö ert A. Fumphrey Funeral Home, West Montsomery Avenue 20850-2805 22. Name and Address of Facility Rockville, Inc. 30 Rockville, Maryland Solvest A. ture of Funeral Service Licenses M00803 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) eques. Enter Underlying Course (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED AMENDED attending physician for use as the burial #23a,27,perME Division of Vital Records, P.O. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b Were autopsy findings available prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene After this 1 🗸 Yes ဥ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident

To the Hospital or Attending Physician:

To the Funeral Director: MILILING

Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 11, 2006

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner

31. Date filed (Month, Day, Year) State DEC 8 Registrar

29b. Signature and title of certifier

32 Registrar's Signature

Medical

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend#17, perInf, G863, 1/8/07 TT Certificate of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:18 AM 2006 RICHARD LANCE HARTMAN De cember 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Under 24 Hrs UNION MEMORIAL HOSPITAL Baltimore C 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F Hours Yrs. 212-48-7559 60 **Director** Oct 1, 1946 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Carroll County Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 890 Sondie Drive Funeral 21157 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: ^{2□}No Vietnam 1 Never Married 2 Married 9 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 M Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Carrier US Government 17. Father's Name (*First_Middle, Last*) **George T. Hartman**Daniel Morrison Danforth permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked ofth any Injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be <u>Helen Jean McKewin</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Argonne Drive, Baltimore, Maryland 2. Disposition (Name of Date 20c. Location - City or Town, State Mrs. Helen Jean Danforth (Mother) 21218 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 12/20/2006 | Baltimore, Maryland 21. Signally of Deportal Station Livensee

Martin D. Dawson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Infarction hour /Medical Du (or as a consequence of): **Examiner** tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine I or Attending Physician: The law requires that the death certificate be executed attracted.

Director: After this certificate has been signed by the attending physician and in by the Innerial director, page 2 should be detached for uses as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Iniurv 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral L 29a. Certifier 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0053373 Vecember 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Kang, MD 1 East University Parkway Baltimore MD 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State Registrar DEC 1 8 2006 losur

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1711 De	hours after ural', or Ita	Completed by Funeral Director	11. Marital Status UNK 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	If	/as Decedent of Yes, specify Cu ☐ Yes 2 No		pecify Yes or No o Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc. hite
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$\mathcal{H}_{\mathcal{S}}$	ad la b	To Be	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	unk
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imore	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☑ Other (Specify)	Removal from State	Place of Dispos cemetery, crem	ition (Name of atory or other pl	ace)	Date	20c. Location - City o	Town, State
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8760,	Physician and burial-transit sthe burial-transit	dical Examiner	23a. Partl. Enter the disease, or comb shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	incations that caused the deat ne cause on each line. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):		ring, such as cardiac			Approximate Interval Between Onset and Death JERRS
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	w requires that the de been signed by the a should be detached f	۵	Part II. Other significant conditions col	ntributing to death but not res	ulting in the und	derlying cause g	iven in Part I.		obacco use contribute t les 2 □ No 3 □ P	o the cause of death?
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f Vit	Physician this certif al directo	To Be	25. Was case referred to medical examiner? 1 Pyes 2 No	Hospital:	ER/Outpatient	3□ DOA O	26. Place of Dea ther: 4 ☐ Nursing H		ence 6 □Other (Spe	əcify)
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	Sta Registra	-	31. Date filed (Month, Day, Year) DEC 1 6	32. Registrar's Signa	iture	and of			100	

		For State Registrar	State o	f Marylaı		artment of F		,	giene Reg. No	06 601	95
Physic /Med		Decedent's Name (First, Middle Anthony Hardin						2. Date of De Month Decembe	ath Day	3. Time of De Year 006 3:00 Pi	
Exam		4a. Facility Name (If not institution Joseph Richey	, give street and nur	nber)			r Location of Deat		- T	y of Death	
Funera Directo		5. Social Security Number 090-64-7138 Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	7. Age (In yrs 57	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	9. Birthplace (State or F Country) Trinidad	oreign
ithe Maryland 7288-f ehow politied	tor	10a. State 10b. County	* 6-1	10c. C	ity, Town or Lo					10d. Inside City	
n with the 3a or 28a	i Director	10e. Street and Number 828 N. Eutaw S	treet			10f. Zip Code 21201				What Country?	
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06-09242 Martin Heen

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tate of Maryland / Department of Health and Mental H	ygiene	0000	101	0
Certificate of Death	Reg. No.	2006	401	91
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		1- For State Registrar	Certific	cate of	Death		Re	eg. No.	00 4019
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Martin L. Henn Martin Henn					2. Date of Deat Month December	th	3. Time of Death 2140 hrs
		4a Facility Name (if not institution, give st Baltimore Washington Medic	·	. 4	b. City, Town, o Glen Burni	r Location of Dea e	ath	4c County of Anne Aru	
Funeral Director		5. Social Security Number 6. Sex 220-36-3168 1 X M Usual Residence of Decedent	7. Age (In yrs. last bi	rthday) Yrs	If Under 1 Yes		lin	th(MM/DD/YYYY) 3, 1937	Birthplace (State or UNK Foreign Country)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene mit: If time 27 is marked other than "natural", or items 23a or 28a-f show any rother traumaric event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10a State 10b. County MD Anne Aru 10e. Street and Number 205 Catalfa Avenue	2. Was Decedent Ever in U.S. Armed Forces? Yes 2 No res, Give Year Dates College (1-4 or 5+)	Pasac 13. Was If Ye	lena 10f. Zip Code 21 Decedent of Hill s, specify Cuba Yes 2 X No s Usual Occupa st of working life	n, Mexican, Puer specify: tion (Give kind o	Specify Yes or No- to Rican, etc.)	White, Specify: .16b. Kind of Bus	American Indian, Black, etc. White
Battimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: Iften Z7 is marked other Inigury or other traumatic event, the Med	To Be (19a Informant's Name/Relationship (Type O . C . M . E . 20a Method of Disposition		111 P	Address (Stre	et and Number o	r Rural Route Num	nber, City or Town	State, Zip Code)
Balti Balti Departm Imports Injury o		1 Burial 2 Cremation 3 4 Donation 5 X Other Specify 21 Sign ture of Funer 1 Direct Licensee 23a Part I. Enter the disease, or complication. List only one cause on each light of the second se	Removal from State in state de lirector tions that caused the death. Do n	story or other	er place) The and Addres	所ず ^{ac} Boar MD 212	d 655 W.	Baltimo	re Street
/Medical xaminer and recused	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	to (or as a consequence of): to (or as a consequence of): to (or as a consequence of):	ated by	atherosc	lerotic c	ardiovascul	lar disease	Between Onset and Death
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Division of Vi To the Hospital or Attending Physi within 24 hours after death To the Funeral Director: After this completely filled in by the funeral dir	Certification: To	Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	28a Date of Injury (Month, Day, Year) 28b. 12/4/2006 2: 2Be. Place of Injury - At home, f (Specify) Hospit	Time of Inju 45 pm arm, street,	1 28c. Inju	ry at Work? Yes 2 No uilding, etc.	28d Describe he coagulopat following 28f. Location (Standard Standard w Injury occurred thy bled in thoracente treet and Number ate Balt. Wa all Dr. Gle	Subject with to chest esis or Rural Route Number, City ash, Med.	
To the Howith 24 P	edical	one) 2 Medical Examiner: On and 29b. Signature and tile of certifier	To the best of my knowledge, de the basis of examination and/or in pranner stated			, death occurred		ind place, and due	to the cause(s) (Month, Day, Year)
St	ate	31. Date filed (Month Pay, Mear)	Medical Examiner 1	11 Penn	Street, Balt	imore, MD 2	1201		
Regist	rar	31. Date filed (Month Pricear) 6 20	Of Marine M.	En	alle s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Carol Johnson 2:52 AM December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TIHORE

7. Age (In yrs. last birthday)

Months Days Hours Min. Examiner NA SINAI HOSPITAL OF BACTIHORE 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 XE 215.52.2016 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at Baltimore MD 1 XYes 2 □ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? if Item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a 38th Street USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Mo Specify: Black Be Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician Nursing Home 12th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Baltimore, Maryland Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 is marked of Thomas W. Rorie Evelyn Toomer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Evelyn Rone / Mother Dumbarton Avenue Balto. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/19/06 21. Signature of Funeral Series Licensee Greene Funoral Services Baltimore MD York Road 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
> 5 ycory Immediate Cause (Final Cardiomyonethy **Physician** disease or condition resulting in death) /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Diabetis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Reuol 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 XNo 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15 wedows have to MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE BRADAUSKATTE SINAL HOSPITAL OF M.V. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

LINDA

As Facility Name (if not institution, give street and number) Arteria Mannessa Assist Living 5. Social Security Name (if not institution, give street and number) Arteria Mannessa Assist Living 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 5. Social Security Name (if not institution, give street and number) 6. Social Security Name (if not institution, give street and number) 6. Social Security Name (if not institution, give street and number) 6. Social Security Name (if not institution) 6. Social Security Name (if not institution) 6. Social Security Name (if not institution) 6. Social Security Name (if not institution) 6. Social Security Name (if not institution) 6. Social Security Name (if not institution) 6. Social Security Name (if not i		For An State Registrar	nend Ite	m Zza, 26	per dr.,	G863, 0 Certifica	1 71076 te of D	7dhb eath	иенка Ну 	/gien Reg. No	.20	06	4019
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Specific Specific	nue		O Married	Armed Forces	?	13. Was Dec	edent of Hisp ecify Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No o Rican, etc.)	0-			
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shck, or heart failure. Also lonly one cause on each line. Interval Between Interval Between Cause (Final disease or condition resulting in death) Sequentially list conditions cause. Einer Underlying cause. Einer Underlying cause. Einer Underlying Cause (Disease or Injury that inhighed events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 17 nonlths? 1 Uves 2 Live 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed? 1 Wes 2 Live 1 Underlying cause given in Part I. 25b. Was case referred to medical examiner? 1 Wes 2 Live 1 University 1 University 2 Live 1 University 2 Live 2 Live 1 University 3 Live 2 Live 1 University 3 Live 2 Live 1 University 4 Live 2 Live 1 University 4 Live 2 Live 1 University 4 Live 2 Live 3 Live 2 Live 2 Live 3 Live 2 Live 2 Live 2 Live 2 Live 2 Live 3 Liv	. 14	1 len	21/1	1 leva		Baltin	ore,	MD 2120)1				
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25. Was case referred to medical examiner? Continuous	Con								perf 1□ Yes	ormed? 2 N	o de	ath?	
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29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	tion	1 Natural	5 Pending investigation	(Month, D	ay Year)	njury			2000100		, 20001160		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	ertification:	3 Suicide	6 ☐ Could not b	_	njury - At home, fa	rm, street, facto			28f. Location	(Street a	nd Number	or Rura	l Route Number,
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	17	- I tomore		Juliang, 6	io. (openiy)				City of 10	rwii, Olai	6/		
one) and manner stated.	ē												
29b. Signature and title of certifier / / / / 29c. License number 29d. Date signed (Month, Day, Year)	Medical Cer	(Check only 2		miner: On the basis	of examination an								

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Division

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

State Registrar

32. Registrar's Signature

ORIGINAL

06-09087

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Elsie Alice Kasson 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1125 hrs Medical Examine November 29, 2006 Elsie Kasson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 6100 Westchester Park Dr #1405 College Park Prince George's 5. Social Security Numberunk 6 Sex If Under 1 Year | If Under 24Hrs 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Director 77 Oct 1, 1929 Country) $_{2}X$ Usual Residence of Decedent Oc. City, Town or Location 10d Inside City Limits any Yes 2 X No or 28a-f show Prince George's College Park MD or items 23a or 28a-f sho must be notified at once. after death with the Maryland Director 10e. Street and Numbe 10g. Citizen of What Country 20740 6100 Westchester Park Drive #1405 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No unk 12. Was Decedent Ever in U.S. Funeral 14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 X No Yes 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify Pages 1 and 2 should be filed within 72 hours after neut of Health and Mental Hygener aut: If item 27 is marked other than "natural", a ror other traumaite event, the Medical Examineer. Specify white ş 16a Decedent's Usual Occupation (Give kind of work don@nk 15 Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State artment o Donation 5 X Other -0 22 Name and Address of Faci State Anatomy Baltimore, MD Board 21201 655 W. Baltimore Street I. Enter the diseas Approximate Interval **Physiciar** e. List only one cause on each line Between Onset and /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Medic

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

Zabiullah Ali, M.D.

=	d.							
dical	UNPENDED	AMENDED						
Physician/Me	IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown	23c If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fetal death		ancy	23d Date of de Month	livery Day	Year
	Part II. Other significant conditions	contributing to death but not r	esulting in the underlyin	ng cause given in Part I.	23e. Did toba	acco use contribut	te to the caus	e of death?
g	Diabetes				1 Yes	2 No 3	Probably 4	✓ Unknown
Completed					24a. Was an autopsy perform	prio ed? dea	r to completio	dings available on of cause of 2 No
l e	25. Was case referred to medical			26.Place of Death (Check	only one)			· · · · · · · · · · · · · · · · · · ·
To B	examiner? 1 Yes 2 No	lospital 1 Inpatient 2	ER/Outpatient 3	DOA Other Nursi	ng Home 5 Re	esidence 6 🗸	Other Scene	
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a Date of Injury (Month, Day, Year)	28b Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d Describe how	w injury occurred		
Certification	3 Suicide 6 Could not I determined	be 28e. Place of Injury - At h	ome, farm, street, factor	y, office building, etc.	28f. Location (Stroor Town, State		or Rural Route	e Number, City
lical (Check only	ian: To the best of my knowled			,	*		s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 30, 2006

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			1 - State Registrar		Cert	ificate of	Death	Reg	. No. UU 6	40200
	nysicia		1. Decedent's Name (First, Middle, Las	Laney				2. Date of Death Month	Day Year	
	Medic xamin		4a Facility Name (If not institution, give	street and number)		-	r Location of Deat	COSTITUCE	4c. County of De	ath
	 neral	*	5. Social Security Number 6. S	SING HOME 7. Age (In yrs. last	birthday)	If Under 1 Year Months Days				irthplace (State or Foreign Country)
D	ector		Usual Residence of Decedent	18	>	4:		UCF. 5, 1	928 N	Carolina
Marylar	fied at	ctor	mp Bultimo	ore Tow	Son	ation				10d. Inside City Limits 1 □ Yes 2 1 No
with the	st be not	Il Dire	10e. Street and Number 509 Joona R	rd.		10f. Zip Code	4		. Citizen of What C	Country?
5-UU36 72 hours after death with the Maryland frature!" or items 23a or 28a.4 show	imporant, it rent 27 is marked other than tradual, or reins 23d of 2day show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armer Forces? 1 Yes 2 No If Yes, Give		as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		nerican Indian, lite, etc.
2-0036 72 hours af	lical Ex	eted b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest gra		6a. Decede (Give ki	ent's Usual Occup	eation during most of wo	rkina I	6b. Kind of Busines	s/Industry
filed within Hygiene.	the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ubo		during most of wo. d)	L	Jarehou	ise
yiand ionid be filed in Mental Hyginarked other	rtic event,	To Be C	17. Father's Name (First, Middle, Last) Crockett Lane	4			18. Mother's Nar	me (First, Middle, M. Thomps	niden Surname)	
and 2 sho	er trauma		19a. Informant's Name/Relationship (7	1 10-1.		Address (Street	1 0 10	ural Route Number, Glen E	City or Town, State,	Zip Code) D 21001
Pages 1 and of He	y or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific			tion (Name of atory or other place ORST V			1) In O.C. K	nills, md
parmit, Pages Department of	any injuran		21. Signature of Funeral Service Lipen			Name and Addre		funeg	1 Hm.	P.A. 21029
	Sag .		23a. P.V.1. Enk r III disease, or comp shoot, or heart failure. List only Immediat J. ause (Final	one cause on each line.		the mode of dyir	ng, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
Physi /Med	dical		disease or condition resulting in death)	a. So the Ce w Due to (or as a consequence						dougs
Exam	niner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence		<i>z</i>				weels
xecuted	the burial-transit	Examiner	Cause. Eitler Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Squavo	Ce of):	C211 1	neng c	ancel	-	months
certificate be executed	the buris	Medical E	(d						
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affer death. To the Finnest Director: After this certificate has been sinned by the attending to the finnest by the attending to the control of the	on es	hysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de: 4 □ Pregnant at time of death 9 □ Unknown	ath 3⊟E	Ectopic pregnancy Other <i>(specify)</i>	,		23d. Date of d Month	elivery Day Year
ires that	be deta	by P	Part II. Other significant conditions of	ontributing to death but not resulting	g in the und	lerlying cause giv	en in Part I.	23e. Did toba		to the cause of death?
e law requires t	2 should	Completed						24a. Was an autopsy	24b. Were	autopsy findings available
VICAL TO CLARA THE CARTER THE	tor, page	Be Con	25. Was case referred to medical				26. Place of Dea	perform 1 Yes 2	d? death? No 1 □ Ye	, _
Physici Physici	al direc	ဂ္	examiner? 1 Yes 2 No 27. Manner of Death		Outpatient b. Time of		er: 4 ☐ Nursing F	lome 5 ☐ Residen		ecity) hospice
STOTI tending leath.	he fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 □	yat k? Yes 2∐No	26d. Describe now	injury occurred	
DIVIX al or Atte	ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.	oletely fille	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death o and/or inve	occurred at the tirestigation, in my o	me, date and place opinion, death occ	e, and due to the cau urred at the time, da	se(s) and manner are and place, and di	as stated. ue to the cause(s)
To th withir	бшоо	Me	29b. Signature and title of certifier	000 in	()	29c. Licens	e number		Date signed (Mor	nth, Day, Year)
,	6		30. Name and address of person who heles who have	completed cause of death (Item 23)	a) (Type, Pi	rint) ,	- RP & 20			40 21204
1.5	Sta		31. Date filed (Month. Day, Year)	32. Registrar's Signature			FFE CL	5, Ball	Joi Ere W	CILLY
R DHMH 17 I	egistr Rev 1/20		DEC 1 8 200	6 fileres H.	Spark					

Registrar DHMH 17 Rev 1/2001

Clarence Landrum State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Dricedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 14, 2006 2120 hrs Medical Examiner LANDRUM CLARENCE B. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Howard County General Hospital Columbia Howard Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 9. Birthplace (State or **Funeral** Country) SC Months Days Hours Min 04/25/1927 79 Director 246-32-3307 \mathbf{X}_{M} Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County BALTIMORE MD 1 Yes 2 No 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene and Martial Hygiene is 77 is marked other than "natural", or items 23a or 28a-f sho mait event, the Medical Examiner must be neitlied at once Director : 23a or 28a-f : notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21229 USA 727MILYER LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married 1X Yes BLACK Yes 2X No specify. 3 X Widowed Divorced Yes, Give Year 1945 - 4<u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 ANIMAL CARE SUPERVISOR U.S.GOVERNMENT 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, the ELSIE KEITH Be BOYCE LANDRUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 4667 RIVERSTONE DRIVE, OWINGS MILL, MD 2117 VALERIE LANDRUM/DAUGHTER 20b. Place of Disposition (Name of cemetery 20a Method of Disposition Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State CROWNSVILLE VET CEM 12/20/06 CROWNSVILLE, MD 21032 Donation 5 Other Specify 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC chature of Funeral Service License Q1 1701 LAURENS STREET, BALTIMORE, MD 21217 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. en Onset and /Medical Death a Exsanguination complicating hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions ē if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed put Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE phy the t 23c. If yes, outcome of pregnancy 23d Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 V No 3 Probably 4 Unknown Endstage renal disease, anticpagulation therapy Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has page 2 performed? death? 1 🗸 Yes ✓ Yes 2 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c, Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only within 2 To the 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 15, 2006 a 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

			1 - State Registrar			Ce	rtificate o	f Death	7		Reg. N	LUU L	Ö	40202
10			1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath		· · ·	3. Time of Death
	Physici		Carmen Marina La	arrabure	de Gorr	io			1	Month Decemb	er 1) 14. 20	Year 06	3:50 p. M
	/Medio		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, Town	or Location				c. County of		3.30 P.
16	LAGIIII	CI	Montgomery Hosp:				Rockvi	11e			M	ontgor	noru	
(E)	Funeral				7. Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Unde	r 24 Hrs.	8. Date of Bi	irth			place (State or Foreign
2.5	Director		220-94-6463	1□M 2 X F	55	Yrs.	Months Day	s Hours	Min.	Month, D., May 8,	a <i>y, Y</i> ea 1 Q	(r) 51 E	Couin Peru	try)
			Usual Residence of Decedent							ilay 0,	1).	<u> </u>	CIU	
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	ocation						1	0d. Inside City Limits
	Man -f sh fied	ţ	Maryland Montgor	nerv	Poto	mac								1 ☐ Yes 2 ☑ No
	28a noti	Directo	10e. Street and Number		μ ο ε ο .	mac	10f. Zip Code				10g. C	Citizen of Wh	nat Coun	itry?
	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11701 Bunnell Co	ourt Nort	h		20854				Pe	ru		
	ms 2	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of	Hispanic O	rigin? (Spe	cify Yes or N		14. Race	- Americ	an Indian,
	fter (r iter	Ē	1 ☐ Never Married 2X Marrie	Armed Fo 1 ☐ Yes If Yes, Giv								Black,	White,	etc.
5-0036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve ates:		1 ☑ Yes 2 □ N	o Specify	Peruv	ian		Specify:	Whi	te
ş	2 hou atura cal E	ed	15. Decedent	s Education		16a. Dece	dent's Usual Occ	upation			16b.	Kind of Busi		
	nin 7: n "n Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1	1 4or 5 : \	(Give life.	kind of work dor DO NOT use reti	e during mo red)	st of workir	ng				
212	with yiene	E	Elementary/Secondary (0-12)	2	1-401 5+/	Homem	aker				l Ow:	n Home	2	
ō		BeC	17. Father's Name (First, Middle, L	.ast)				18. Moth	ner's Name	(First, Middle	e, Maide	en Surname,)	
au	ld be enta ked ic ev	To B	Ricardo Larrabui	re				Mari	na Es	pinosa	ı			
7	2 should be and Mental is marked of aumatic ev	-	19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Maili	ng Address (Stre			<u>-</u>		or Town, S	tate, Zip	Code)
≅	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		Jorge F. Gorrio	/ Husban	d	1								and 20854
Ġ,	Hea Hea tem		20a. Method of Disposition				osition (Name of matory or other p			ate	-	Location - C		
ᅙ	g = 2, g		1 Burial 2 Ki Cremation		Siale			4	Dog 1"	7 2006	Date	h	M -	1 1
Baltimore, Maryland 2121	it. Pag intment intant; I injury c		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service	icensile	MONE		Crematorio							
g	permit. Pag Department Important: any injury once,		21. Signature of Puneral Service	Top	M008	896 75	557 Wiscon	diiphréy sin Ave	Funer Bet	al Home, hesda, l	/Beth Mary]	nesda-Ch Land 200	1evy (814–3	Chase, Inc. 3501
			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that conly one cause on e	aused the death	n. Do not en	ter the mode of d	ying, such a	s cardiac o	r respiratory	arrest,			Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition		oblastor	ma								Onset and Death
	/Medical	-	resulting in death)	d	or as a consequ		-						\neg	
	Examiner			h									i	
4		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Diogram of milu.) that initiated events	Due to ((or as a consequ	uence of):								
	cuted id ansil	Examiner	Cause (Disease or injury that initiated events	C										
Ó	execan an an rial-tr	Ä	resulting in death) Last	Due to ((or as a consequ	uence of):								
68760	certificate be executed ding physician and se as the burial-transit	g		d										
	tifical g ph as th	/Medical		1										
ŏ		_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome pf pregna	ncy	75-11					23d. Date	of delive	ery
Ď	at the death by the atten stached for u	Physicia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregn	oirth 2 ☐ Fetal	eath 5	∐Ectopic pregnar ☑ Other <i>(specify)</i>	icy				Mont	h	Day Year
0	the sy the ache	hys	9 □ Unknown	9□Unkno	own									
J.	The law requires that the death the has been signed by the atter hage 2 should be detached for u	by P	Part II. Other significant condition	ns contributing to de	eath but not resu	ılting in the u	nderlying cause (given in Part	1.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
ğ	quire n sig ald b									10	Yes	2 № No 3	☐ Prob	ably 4 ∐Unknown
S	w rec	Completed								24a. Was	s an	24h W	ere autou	psy findings available
E E	The law cate has page 2 s	盲	_		-					auto	opsy formed?	pri	or to con ath?	mpletion of cause of
Vital Records,	(0 1		OF Was assessed to see the last							1□ Yes		No 1 [Yes	2 No
=	sicial certi recto	Be	25. Was case referred to medical examiner?	Hospital:				Maria		(Check only				Inpatient
ō	Phys rthis raldii	1.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2 1	28b. Time o	IL JUDON	4 L N		ne 5∐Res 8d. Describe				Hospice
2	ding f	io	1 ☑ Natural 5 ☐ Pending	(Mon	th, Day Year)	Injury	W	ork? ∐Yes 2 ⊑		.ou. D0301106	, now mj	iniy occurred		
<u>s</u>	death death ctor: / the	ical	3 Suicide 6 Could no	ot be	of injury - At ho	me farm str	reet, factory, offic			8f Location	(Street s	and Number	or Puro	l Route Number,
Division or	or Atten	Certification:	4 ☐ Homicide determin	buildi	ing, etc. (Specify	<i>()</i>	cot, ractory, onto	•	1	City or To			or nurai	nouse warnber,
_	Hospital or Attending Physician: 44 hours after death, Funeral Director: After this certific tely filled in by the funeral director,		29a. Certifier 1 🖸 Certifying	Physician: To the	best of my kno	wledge, deat	h occurred at the	time, date a	and place, a	and due to the	e cause	(s) and man	ner as st	rated.
	To the Ho s within 24 h To the Fur completely	Medical	(Check only 2 ☐ Medical E	examiner: On the b	asis of examinatine	tion and/or in	vestigation, in m	y opinion, de	eath occurre	ed at the time	e, date a	ind place, an	nd due to	the cause(s)
	To COT	2	29b. Signature and title of certifier	· • • • • • • • • • • • • • • • • • • •		2		nse number				ate signed (
}			Cynthia n	2 Mille	am	2	HO	0580	132		10	2-14	7-2	2006
^	7 /		30. Name and address of person v	vho completed caus	se of death (Item	23a) (Type,	Print)							20855
2	U		Cynthia M. Willi	ams, D.O.	., Monte	omerv	Hospice	, 6001	1 Muna	caster	Mil	l Rd.	, Ro	
	Sta	te	31. Date filed (Month, Day, Year)	32. R	Registrar's Signa	ture								

Registrar DHMH 17 Rev 1/2001

State

			For State Registrar	State of Mary		partment of ertificate of		nd Mental Hyg	jiene leg. No. 0 0	6 40203
	Physici		1. Decedent's Name (First, Middle, Last)	ORBER	·			2. Date of Dea Month	th Day	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	or Location of	Death December	4c. County of	
	Funeral		NORTHWEST HOSPITA 5. Social Security Number 6. Sex		yrs. last birthda		LLSTOWN		BALTI	3. Birthalana (Ctata or Farrisa
	Funeral Director		142-30-6439	M 2□F	88 Yrs	Months Days		Hrs. 8. Date of Birth Month. Day 05/15/	1918	POLAND
	yland now		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
	8a-fet	Director	MD N/A	1	BA	LTIMORE				1 X Yes 2 □ No
	3a or 2		10e. Street and Number 4169 CREST HEIGHT	S ROAD		10f. Zip Code	21208	ļ.	0g. Citizen of Wh	at Country? USA
	ieme 2	Funeral	77 - 71 - 11 - 11 - 11 - 11 - 11 - 11 -	12. Was Decedent Ever Armed Forces?	r in U.S. 1	3. Was Decedent of If Yes, specify Cul	Hispanic Origir ban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc.
036	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or fleme 23s or 28s-f show ent, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
21215-0036	n 72 he "natus edical	leted	15. Decedent's Educ (Specify only highest grade		(G.	cedent's Usual Occuve kind of work done DO NOT use retire	during most o	of working	16b. Kind of Busi	ness/Industry
212	ad withi giene. •r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	MAS				CONSTRU	CTION
land	id be file ental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Last) SCHIA		LO	RBER		s Name <i>(First, Middle, I</i> B TAINABLE)		UNOBTAINABLE)
Maryland	permil. Pages 1 and 2 should be filed within 72 hours after death with lihe Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel; or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Experiment must be notified at once.		19a. Informant's Name/Relationship (Type		19b. Ma	iling Address (Stree	t and Number	or Rural Route Number	, City or Town, St	ate, Zip Code)
	s 1 and if Health Item 27 other tr		FRANK OKSMAN / SC 20a. Method of Disposition	2	Ob. Place of Dis	DUFF IALU position (Name of rematory or other pla	1	RACE - PERI	KY HALL, 20c. Location - Ci	
Baltimore,	Pages tment of tant: If it jury or o		1	A	-	N CHIZUK		2/15/2006	BALTI	MORE, MD
Ba	permij. Departr Importe eny inj		21. Signature of Funeral Service License	Cuttler		22. Name and Addr		SOL LEVINS	SON & BROPIKESVIL	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do not e					Approximate Interval Between Onset and Death
Ĭ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co		ENAL	EAIL	URE:		Oliset and Death
ı	Examiner	2	Sequentially list conditions b		ARDI	omyopr	YMTF	4		
	uted d ansit	Examiner	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a co	sequence or):	1.				
8760,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
687	tificate ng phys as the	fedical	d							
P.O. Box	eath certific ettending p for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pr	Fetal death	B⊟Ectopic pregnanc	ÿ		23d. Date of	,
Ö.	s that the death ned by the etter e detached for r	hysic	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time 9☐ Unknown	ordeath :	Other (specify)				
ds, F	6 0 0	d by P	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	D	ute to the cause of death?
Records,	aw require is been sig 2 should b	Completed						24a. Was a	n 24b. Wei	re autopsy findings available
								autops perform 1 Yes 2	y prio ned? dea	or to completion of cause of
Vital	/sicien: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{N} \) No	ospital:	2 ☐ ER/Outpat	est 30 DOA Ot		Death Check only one		10
<u> </u>	<u> </u>		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea		of 28c, Inju			w injury occurred	
Division of	r Attending Physicien: er death. rector: After this certifics i by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm,]Yes 2□No		reet and Number	or Rural Route Number,
É	ours after ours after oral Dire		4 Hornold	building, etc. (S	pecify)			City or Town	, State)	
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the to	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exa and manner stated.	y knowledge, de mination and/or	ath occurred at the ti investigation, in my	me, date and p opinion, death o	place, and due to the ca occurred at the time, da	use(s) and manne ate and place, and	er as stated. I due to the cause(s)
	vithir To th	W	29b. Signature and title of contifier	M-91	ala m	29c. Licen			d. Date signed (A	- 14
	I Fi		30. Name and we ress of person who con	•			4141	a D 2000	Decamb	in 13th, 2006
L	U		MATHWEST	HOSPITHL	RENT	TER R	ANDAU	RP ME	WC.	21133.
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 8 20	32. Progistrar's S	Signature	parte				moved of the Park Transfer

			For State Registrar	State of M	Marylan		artmen rtificat					giene leg. No.	006	402	501
	Dhuaisi		1. Decedent's Name (First, Middle	, Last)							2. Date of Dea Month	th Day	Year	3. Time o	of Death
	Physici /Medi		Bette	M. McLea	n						Decemb			5:1	5A ^M
	Examir		4a. Facility Name (If not institution	, give street and number	er)		4b. City,	Town, or	Location of	of Death		4c. Cot	unty of Death		
			Brighton Gar					thes				Mo	ntgome		
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	Il Under: Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State ntry)	or Foreign
	Director		256-22-9046			Yrs.					Sept. 2	9, 19	22 Te	nnesse	e e
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside (City Limits
	Maryl.	5	Maryland Montg	Omerv			these	la.							2 2 No
	the N	ect	10e. Street and Number	Oliciy		De	10f. Zip					10a Citizen	of What Cou	otn/2	
	72 hours effer death with the Maryland netural', or fams 23e or 28e-f show alsal Examinar roust be notified at	Completed by Funeral Director	5550 Tucker	man Lane			101. 210	2085	12					ind y :	
	eath	erai		12. Was Deceder	ot Ever in II	S 13	Was Docar			ain? (Sne	offy Ves or No-	U.S	· A · Race - Ameri	can Indian	
	ter d	'n.	11. Marital Status 1 □ Never Married 2 □ Marr	Armed Force	s?	.0.	If Yes, spec	rify Cuba	n, Mexican	, Puerto	cify Yes or No- Rican, etc.)		Black, White		
38	rs ef	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 🗌 Yes	2 No	Specify:			Spe	ecify: Wh	ite	
ğ	72 hours "netural", Mical Exp	ed	15. Decedent			16a. Dece	dent's Usua	al Occupa	ation			16b. Kind o	of Business/Ir	ndustry	
15	c ' 4	ple	(Specify only highes Elementary/Secondary (0-12)			(Give	kind of wo	rk done d se retired	<i>luring</i> mosi)	t of workii	ng			,	
7	filed within I Hygiene. other than "	E	Elementary/Secondary (0°12)	College (1-4c	JI 5+)	H	omema	ker				Own	Home		
b	be filed withintal Hygiene. Id other than	0	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden Sun	name)		
<u>a</u>		To B	Harold Mill:	iken					Ma	ud	Alver	son			
Maryland 21215-0036	2 should and Men In marke numatic	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	or Rura	l Route Numbe	r, City or To	wn, State, Zij	Code)	
	rt.		Elizabeth McLe	an - Daught	er	122	20 Da	ncre	st Dr	ive,	Clarks	burg,	Mary1	and 2	20871
ē	es 1 an of Heal of Item 2 or other		20a. Method of Disposition		20b. P	Place of Dispo					ate		on - City or T		
Ĕ			1 ☐ Burial 2 ② Cremation 4 ☐ Donation 5 ☐ Other (S)							ium	12/15/0	6 Alex	xandri	a, Vir	ginia
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service			NF:	Name an	d Addres	s of Facilit	Y ama	P.A.,	Firmore	a 1 II am	•	
ä	80 E 8 8		Jones I K	- Wel	lear						Damascu				12
			23a. Part1. Enter the disease, or	complications that caus	ed the deat								Lyland	Approxima	ite
	Physician		shock, or heart lailure. List Immediate Cause (Final		_									Interval Be Onset and	Death
٠	/Medical		disease or condition resulting in death)	_ a	iac An										
	Examiner					Artery	Dise	266							
		e	Sequentially list conditions, if any, leading to immediate		as a conseq		DIOC	450							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_{c.} Hype	rtens	ion									
Ć	be executed icien and burial-transit	Exa	resulting in death) Last		as a conseq	uence of):									
8760,	cate be executed physicien and the burial-transit	Cal		_{d.} Hype	rchole	estero.	lemia								
9	The law requires that the death certificate site hes been signed by the attending physicage 2 should be detached for use as the								_						
Вох	eath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			∃Ectopic pr					23d.	Date of deliv	ery	
	deat e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐XNo	4□Pregnant	at time of d		Other (sp						Month	Day	Year
P.0	at the de by the	hys	9 Unknown	9□ Unknown	1										
	es thai igned t	by P	Part II. Other significant condition	_	but not res	ulting in the u	nderlying c	ause grve	n in Part I.		23e. Did to	bacco use c	contribute to t	he cause of	death?
Ë	w require been sig should b	ed	Alzheimer's I)isease							1 🗆 Y	es 2 🗆 No	o 3 🗌 Prol	oably 4 🔀	Unknown
ပ္ပ	awre s bec 2 sho	Completed	Osteoporosis								24a. Was a		b. Were auto	psy findings	available
R	The la	E	•								autops perfor	med?	death?	mpletion of	cause of
Division of Vital Records,		0	25. Was case referred to medical						26 Place	of Death	Check only or		1 ∐ Yes	2□ No	
<u> </u>	Attanding Physician: r death. sctor: After this certifically the funeral director, it	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	itient 2 🗆	ER/Outpatier	nt 3□ DC	Othe			ne 5□Resid		Other (Speci	6v)	
ठ	g Ph ter th		27. Manner of Death	28a. Date of In		28b. Time o		8c. Injury Work			28d. Describe h				
<u>o</u>	nding l ath. r: After e funer	atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	Jay (Gai)	Injury	м	1 🖺	r Yes 2 □ t	No					
Vis	Attandi ar death. actor: A by the fu	Ę	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	289. Place of	Injury - At ho	ome, larm, sti	reet, factory	, office		2	28f. Location (S	treet and Nu	umber or Run	al Route Nur	nber,
ā	al or Att	Certification:	4 LI Hornicide	building,	etc. (Specify	y /					City or Tow	n, 31210)			
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in b		29a. Certifier 1 Certifyin	g Physician: To the be	st of my kno	wledge, deat	h occurred	at the tim	e, date an	d place, a	and due to the c	ause(s) and	manner as s	tated.	
	na Ho n 24 l na Fu iletely	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner	of examina	tion and/or in	vestigation	, in my or	binion, deal	th occurre	ed at the time, d	ate and plac	ce, and due t	o the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certified	MAL	Hal	PP	290	License	number		2	9d. Date sig	gned (Month,	Day, Year)	
				1 soft	Wen	4	1	D536	91			Decem	mber 14	200	6
	10		30. Name and address of person	who completed thuse o	f doath (tterr	n 23a) (Type.	Print)							. ,	-
	Ψ		Ajay Reddy, N				-	ard,	Bet	hesda	a, Mary	land	20817		
	Sta	ate	31. Date liled (Month, Day, Year)	32. Regis	strar's Signa										
	Regist		DEC 1 8 20	Of Made	1 15.	. 45004									

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>				F	Reg. No.	2006	40205	
¥.	Physici /Medic		1. Decedent's Name (First, Middle, Las Norma Janet M	lontgomery						Date of Dea Month Decembe	Day	5, 2006	3. Time of Death	
*	Examin	er	4a. Facility Name (If not institution, give Calvert Manor Head		- 0 h	4b. City, T Risi		Location of	Death			County of Death	1	
*:	Funeral Director		5. Social Security Number 6. Security Number 046-09-1629	7. Age (In	yrs. last birthday) Yrs.	If Under 1		If Under 2	Min.	Date of Birtl (Month, Day pril 6	h /, Year)	9. Birth Cou	nplace (State or Foreign untry) Meticut	
	Maryland f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Harford		c. City, Town or Le Havre de								10d. Inside City Limits 1 XYes 2 ☐ No	-
	th the	Director	10e. Street and Number			10f. Zip (Code		 		10g. Citi	zen of What Cou	untry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If term 27 is marked other then "neturel", or itema 23a or 28a-f show eny injury or other treumatic event, the Moulcal Exercities registed in Item Intilified at ODGE.	by Funeral	666 Chesapeake Dr. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:		Was Decede			in? (Specif Puerto Rid	fy Yes or No- can, etc.)		U.S.A. 14. Race - Amer Black, White	ncan Indian,	
21215-0036	within 72 ho ine. ihen "netur im alleri	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d retired	during most ()	of working		16b. Kii	nd of Business/l	ndustry	
d 2	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		<u> </u>	Home	rmar		's Name (I	First, Middle,	Maiden	Home Sumame)		_
ylan	should be ind Menta i marked umatic ev	To B	Dominic Sbrocco					Conc	cetta	Fiore				
Mar	d 2 sho		19a. Informant's Name/Relationship (7 Charles D. Montgo		1							r Town, State, Zi 20185	ip Code)	
e e	f Health item 27 other tr		20a. Method of Disposition	2	20b. Place of Dispo cemetery, cre	osition (Name	e of		Dat	-		cation - City or T	Town, State	
<u>E</u>	Pages nent of I ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Angel Hi	ll Cen	1ete	ry 12					ace, MD	
Balt Balt	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licen	2 10	nan in	2, Name and Itchel 23 S.	L-S Was	ss of Facility mith T hinate	Funer	al Hom r. Ha	ie. F	P.A. de Grac	e. MD 21078	8
	The law requires that the death certificate be executed WAMANA ate has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit are.	dical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a	ons vence of):	rten L	рер	Dis	Cas				Interval Between Onset and Death	
P.O. Box 6	that the death certificated by the attending placed for use est	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					2	23d. Date of deliv Month	very Day Year	
rds, P.	quires that I in signed by uld be deta	ρ	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the u	inderlying ca	use give	en in Part I.		23e. Did to	1.	/	the cause of death?	
Division of Vital Records,	: The law requir cate has been s , page 2 should	Completed								24a. Was a autop perfor	sy		copsy findings available omptetion of cause of	
<u>===</u>	sician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 🗆 DOA	Othe			Check on or		3 □Other (Spec	4.1	-
ı of	ding Phys h. After this funeral di	n: To	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time o		c. Injury	at		d. Describe h			ny)	-
Division	or Attendent ifter death Director: in by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, st	М	10	Yes 2 □N		f. Location (S City or Tow			ral Route Number,	-
_	To the Hospitei within 24 hours a To the Funeral t completely filled	edical Co	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	ysician: To the best of m liner: On the basis of exa and manner stated	amination and/or in	th occurred a evestigation, i	it the tim	ne, date and pinion, death	l place, and n occurred	d due to the o at the time, o	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
•	To the Within 1 To the comple	Me	29b. Signature and title of certifier	MI>					68			e signed (Month		
	b		30. Name and address of person who of 28/ E- Main	c/ //.		Print)	N	215	21	911		118/06		
2100	Sta		31. Date filed (Month, Day, Year) DEC 1 8 20	32 Registrar's	Signature	and of								

			amend #5 PerInf Amend #8 perFH,	TG877 3/5/08 11 51ac 383, 1/19/07 II ame State of Maryland /	k Indelible Ink. Ens	sure All Copies A	re Legible. 7 vt
			1_ For Amend item#7, p	erFh, g862, 12/16/06	Department of Healtr Certificate of Deat	i and Mental Hygie h	. No. 2006 40206
W		Ŷ	Decedent's Name (First, Middle, La		. 1	2. Date of Death Month	india o o o o o o o o
1	Physicia /Medic		McCoy 1	J. IVala	Chi	1)ec-	13-2006 645 M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Locatio	on of Death GR	4c. County of Death
⊕- -	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last bi	Months Days Hours	er 24 Hrs. 8. Date of Birth	12/1914 9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	□M 2×F 92 87	Yrs. Mortale Baye Treate	08-10	1914 "UH
	ryland how at		10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	he Ma 28a-f s otified	ecto	MD HOW	ARD EI	Kride E	100	1
	3a or 3	Funeral Director	10e. Street and Number	reenmoun	TN 210	75	LLS A
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic of If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	ırs afte Il", or il xamin	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Speci	fty:	Specify: BLACK
21215-0036	72 hours after death with the Maryland Inatural; or items 23a or 28a-f show dical Examiner must be notified at	eted	15. Decedent's E (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during m	nost of workina	6b. Kind of Business/Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		Domestic
	e filed al Hygi other vent, tl	Be Co	17. Father's Name (First, Middle, Last			ther's Name (First, Middle, Ma	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If the Z1 is marked other than "natural", or items Z3a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2		rner			tson
Mar	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship (rype. Print) 191 Verhew 5	o. Mailing Address (Street and Num OG6 WhetsTor	0 0 1	nb = 100 21044
ore,	es 1 ar of Hea of Item 3		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	20b. Place of	of Disposition (Name of ery, crematory or other place)	T	Oc. Location - City or Town, State
Baltimore,	t. Pages tment of tant: If It jury or o	172	4 □ Donation 5 □ Other (Special	(a) (a)		12-15-06	Delawase
Bai	permit. I Departm Importar any inju		21. Signature of Juneral Service Lice	ISEE A STATE OF THE STATE OF TH	22. Name and Address of Far 4600 USE	1 iouac	sureral Home
ħ.	40.0		23a. Part F withe disease, or come should be read allure. List only	plications that caused the death. Do one caus, on each line	not enter the mode of dying, such	as cardiac or respiratory arres	t, Approximate Interval Between
d	Physician	H	Immedi ne C-use (Final disease or ondition resulting in death)	a Al-Terrosc	levotic Na		Onset and Death
	/Medical Examiner		(ue to (or as a consequence	of):		2
	D ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):		
_	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	of):		
760,	be icis	_		_d			
(6876)	ertificat ng phy e as the	Medi	IF FEMALE:				
Вох	eath ce attendi for use	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death	h 3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	law requires that the death certificate as been signed by the attending physic should be detached for use as the	Physician/Medical	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□Unknown	o li o ilioi (speciny)		
	res tha igned be det	þ	Part II. Other significant conditions	ontributing to death but not resulting	in the underlying cause given in Pa		cco use contribute to the cause of death?
Sorc	v requi	Completed				1 Yes	
Rec	The lav	dmo				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
ital		Be C	25. Was case referred to medical examiner?		26. Pla	1 Yes 2 ace of Death (Check only one)	I □ Yes 2 □ No
or \	Physician: r this certific ral director,	ဥ	1 ☐ Yes 200 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/O 28a. Date of Injury 28b.		Nursing Home 5 Resident	ce 6 Other (Specify)
ion	Attending ir death. ector: After by the funer	tion	1 Natural 5 ☐ Pending 2 Accident investigatio	(Month, Day Year)	Time of Injury at Work? M 1 ☐ Yes 2		injury occurred
Division or Vital Records,	or Atte	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying P	nysician: To the best of my knowledg	e, death occurred at the time, date	and place, and due to the cau	se(s) and manner as stated
	he Hos in 24 h he Fur pietely	Medical	(Check only 2 Medical Exa	miner: On the basis of examination a and manner stated.	nd/or investigation, in my opinion,	death occurred at the time, dat	e and place, and due to the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier	10/0/-	29c. License numbe	_	I. Date signed (Month, Day, Year)
	. T		30. Name and address of person who	completed cause of death (Item 22a)	(Type, Print)		1414/06
	3 '		- 1 / 1 / 1	ine and 115 Ro	ester ho	Elen Barnin	e mo 2/060_
		te	31. Date filed (Month Day, Year)	32. Projistrar's Signature	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend item#11,12,15,16a-b,18,19a-b, 2a-c,22 perfl 1862, 12/16/06 IT Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1255 06 Anthony McFadden 06 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balt, more Sinai Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2□ F Director 50 Oct 5, 1956 214-68-3789 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ns 23a or 28a-f show must be notified at Director MD Baltimore 1√Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with items 23a 5225 Linden Heights Avenue

11 Marital Status unk | 12. Was Decedent by Funeral 21215 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No U1
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. unk 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th laborer construction unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk-Be is marked Mildred McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
314 Lori Drive Apt B, Glen Burnie, MD 21060
2491 W. Belvedere Avenue Baltimore, MD 212 19a Informant's Name/Relationship (Type. Print) Shannon Dixon/ Niece Sinai Hospital permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Baltimore, Crematory 12/16/2006 Glen Burnie, MD

22. Name and Address of Facility Fari P. Chee Funeral Services, PA
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Spate Bayview Crematory 4 □ Donation 5 ₩ Other (Specify) in state 21. Signature of Funeral Se Director 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Infective Endo carditis **Physician** dan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown カルの カアルク イル I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Roly substance 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ⚠ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ■ npatient 2 ER/Outpatient 3 DOA Other: 4 \sum Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 1,006

Registrar
DHMH 17 Rev 1/2001

State

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

J. Wiesenberger

			For State Amound JEL7 Par FH	State of Maryland	Department of Health and Certificate of Death	Mental Hygier	ne
			1. Decedent's Name (First, Middle, Last)	3602 12/10/00 SII	Certificate of Death	Reg. f	40.206 40208
	Physic /Medi		Lucille	Nay	lov		Day Year
	Exami		4a. Fecility Name (If not institution, give s	reet and number)	4b. City, Town, or Location of Dea		lc. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Da/timore
	Director		49-10-1-100	M 207 87	Yrs. Months Days Hours Min	Month, Day, Yea	9. Birthplace (State or Foreign
	yland iow		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location		10d. Inside City Limits
	Be-feh	Director	MD, NA	B	12-91MOTE		1 TYes 2 No
	death with the Maryland ms 23s or 28e-f ehow	Dire	10e. Street and Number	TST. NOT.	10f. Zip Code	10g. (Citizen of What Country?
	me 23	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
36	rs after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	to rican, etc.)	Black, White, etc. Specify: PS/ NA K
21215-0036	within 72 hours after ene. than "naturel", or ite	eted	15. Decedent's Educ (Specify only highest grade	ation 1	6a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of wo	42	397AN 200-1 7 6205
	e filed of Hygie other	Be Co	17. Father's Name (First, Middle, Last)		18. Mg/her's Na	me (First, Middle, Maide	Surame)
Maryland	ould be Mental varkad c	To	Harry Naylor		10/2	T NAYL	OR BROWN
Mar	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importents if item 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other treumatic event, the Madical Examiner must be notified at once.		19a. Informant's Name/Relationship (Typ	SOA/	9b. Mailing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
ore,	of Health fitem 27 r other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		of Disposition (Name of terry, crematory or other place)	Date / 20c.	Location - City or Town, State
Baltimore,	permit. Pages Depertment of I Importent: If it Imy Injury or o		4 □ Donation 5 □ Other (Specify)	1 //	E/RD 1241	4/01 GA	onsulla MVI
Ba	permit. Depertuimport. any inj		21. Signature of Funeral Service Licenser		22. Name and Address of Facility	707REDAIL	TON THE DINGS
			23a. Part Enter the disease, or complic shock, of hear failure. List only one	ations that caused the death. D	o not enter the mode of dying, such as cardia	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Atheroscler	rotic Cardiovasc		15 ease Onset and Death
	Examiner			Due to (or as a consequent	ce of):		
-	pe tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):		
2.	execut n and ial-tran	Examin	that initiated events resulting in death) Last	Due to (or as a consequence	ee of):		
8760,	cate be executed physicien and the burial-transit	dical	d.				
9 X	eath certific attending p	/Mec	IF FEMALE:	c. If yes, outcome of pregnancy			
Box	death	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of delivery Month Day Year
P.0	that the de led by the detached		9 ☐ Unknown Part II. Other significant conditions contr	9☐ Unknown	T in the underlying seven in Cost I	02a Did tabaasa	
Vital Records,	9 G	ed by	Rectul Bl	of ding	g in the underlying cause given in Part I.	1 ☐ Yes 2	use contribute to the cause of death?
eco	law requir as been s 2 should	Completed		0		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
						performed? 1 ☐ Yes 2 ☑ N	death?
f Vit	ysic is ce direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho	spital: 1 ☐ Inpatient 2 ER/0	Other	th Check only one	& □Other (Specific)
			27. Manner of Death 1. ☐ Natural 5 ☐ Pending		o. Time of linjury at Work?	28d. Describe how info	
Division	ten for:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,	M 1 Yes 2 No	28f Location (Street a	nd Number or Rural Route Number.
ă	Hospital or Attending 4 hours after death. Funerel Director: After tely filled in by the fune		4 Homicide determined	building, etc. (Specify)		City or Town, Stat	e)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	r: To the best of my knowled r: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date ar	s) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	44	29c. License number		ate signed (Month, Day, Year)
	9	4	Tativero	tylle	NO036.	819 De	cember 14,2006
	6		So Name and address of person who com	pleted cause of death (Item 23a	NDY Thuest H	spital	Center
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Anarile	VT Ka.	
3	Registr	ar	DFC 1 8 200	O DEMENDED SO			

		•	1 - State Registrar	State of Maryla		artment of H			iene 0 0	6 40209
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physici		Robert C. Norton					Month	Pay 200	06 10:20 PM
1	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	000	4c. County of	
	LXaiiiii	٠.	Salisbury Re	hab & Nursin	nactt	Sali	sbur	`Y	Wi	comica
	Funeral		5. Social Security Number 3 6. Se	x 7. Age (In yrs	. fast birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth	Vaari	Birthplace (State or Foreign Country)
	Director		070-14-1208	^{2M 2□F} 90	Yrs.	Months Days	Hours Mir	June 30,	1916 N	New York
	P .		Usual Residence of Decedent			1				
	rylar how		10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	Ba-f-e	8	MD Wicomico		Salisbu	ry				1 ☐ Yes 21 No
	or 26	Se	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23s or 28s-f ehow ha Medical Examirer must be notified at	by Funeral Director	27115 Barwick Driv				21801		US	A
	r de	ne Ine	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
36	or it	F.	1 ☐ Never Married 2 📉 Married	1 X Yes 2 □ No If Yes, Give		1□ Yes 2K No	Specify:		Specify:	white
21215-0036	urel	g p	3 Widowed 4 Divorced	Year or Dates: 42	,,,,					
5	"net	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of w	orking	16b. Kind of Busi	ness/Industry
12	withis		Elementary/Secondary (0-12)	Cotlege (1-4or 5+) 5+			•			
	Hygie ther nt, I		17. Father's Name (First, Middle, Last)	JT		special		ame (First, Middle, M	FE	
Maryland	d be	Be	Robert Clinton No	rton				le Gerald		
2	d Me mark matic	2	19a. Informant's Name/Relationship (T)		19h Mailir	ng Address (Street		re Geraru Rural Route Number,		
Ma	d2s than than trau		Helen Norton/spou							
ē,	Hee Hee	ŀ	20a. Method of Disposition		Place of Dispo	sition (Name of		Salisbury,		U L ity or Town, State
ē	ages int of t: If li		1 Burial 2 Cremation 3 F		cemetery, crer	natory or other plac	e)			,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow expiritury or other traumatic event, the Medical Examinat must be notified all once.	}	4 Donation 5 Other (Specify)		20	. Name and Addres	re of Eacility			
Ba	Depariment of the part of the		21. Signature of Euroral Service Licens	Nade Directo	r St	ate Anato	omy Boar	d 655 W.	Baltimo	re Street
			23a. Part1. Errer the disease, or comp.	cations that caused the dea		ltimore,			net .	Approximate
			shock, or heart failure. List only o	ne cause on each line.		/-	335011 43 041411	o or rospiratory arre	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	confe	el u	· hes	41	facti	ne	year-
	Examiner			Due to (or as a conse	quence of):	1.11	1.			
		-	Sequentially list conditions, if any leading to immediate	Due to (or as a conse	quence of):	6710	4 con			year-
	nsit	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							2
<u>.</u>	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760,	The law requires that the death certificate be executed lie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical	· ·	4						
89	ificate g phy as the	0	-							
Вох	leath certific attending p	₹	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr		<u> </u>			23d. Date	of delivery
	death a atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	n Day Year
P.0	that the deatt ed by the atte detached for	hys	9 Unknown	9□ Unknown						
	signed by det	by P	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
Records,	quire in sig uld b							1 □ Ye	s 2 10 40 3	☐ Probably 4 ☐Unknown
၀	aw requir	Completed						24a. Was ar	24b. We	re autopsy findings available or to completion of cause of
	The lav	E						autops	ned? dea	ath?
of Vital		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 eath (Check only one		Yes 2 No
>	Physiclen: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☑ No	lospital:	☐ ER/Outpatien	t 3 DOA Othe		Home 5 ☐ Reside		(Specify)
0	g Physical diseal di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe ho		
0	ath. r: Att	ate	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monar, Day rear)	Injury		Yes 2 □ No			
Division	ar de recto by th	H	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number	or Rural Route Number,
ā	s after selection and property	Certification;		building, oto. (opeo	·1 y)			Ony or rown	, State)	
	t hount uner uner		29a. Certifier 1 Certifying Phy (Check only 2 Madical Exemi	sician: To the best of my kr ner: On the basis of examin	owledge, death	occurred at the tim	ne, date and place	e, and due to the ca	use(s) and mann	er as stated.
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Medical	one)	and manner stated.						
	T V	-	29b. Signature and title of certifier	100		29c. License	number	0 29	a. Date signed (Month, Day, Year)
				06-12-7		02	114	7	14111	106
			30. Name and address of person who co		m 23a) (Type,	Print)	1	2 1-1	/	7
			31. Date filed (Month, 1997, Kear)	32. Registrar's Sign	WOC	VIVIC	Hue,	sall5 bl	ry in	D 21804
	Sta Registr		VEC 16	2006	16	Coast .			*	

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Parsons, Junior Kenneth 41 PM December 2006 /Medical 4a. Facility Name (If not institution, give street and number) Johns 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HODKINS BAVVIEW Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1**X** M 2□ F Director 213**-**70-1870 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 27 is marked othar than "natural", or Items 23e or 28e-f show traumetic event, the Medical Examinat must be notified at MD Baltimore 1 ☐ Yes 2√ No Director Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2406 Key Way 21222 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 12 lead painter inspector city of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Be unk Kenneth J. Parsons Sr ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mary Anne Long/friend 2406 Key Way Dundalk, MD 21222 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of H ant: If ite 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 NOther (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronal d ce Licensee S. Wade 2a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OV Sequentially list concilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 은 2X ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Funerel Director; After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To tha Funerel Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Fo the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 83 December 6, 2006 550 HOFKINS MIEWEICLE 30. Name and address of person, completed cause of death (Item 23a) (Type, Print) Greenough III 15, BALTIMORE MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

ORIGINAL

Registrar

2006

P.O. Box 68760,

Division of Vital Records,

				1 - For State Registrar	State of Maryla	nd / Depa				2000	Ln211
				1. Decedent's Name (First, Middle, Last)	-	 -		2. Date of Death		3. Time of Death
		Physici /Medi		Marjorie A. Pokor	ny				December	12, 2006	10:10 PMM
		Examir		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Deat	h
_				Atlantic General			Berlin			Worces	
0		Funeral Director		5. Social Security Number 6. Se 101–24–6732	x 7. Age (<i>ln yn</i>	s. last birthday). Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign untry)
1210				Usual Residence of Decedent	7.	,	1		July 22,	1931 New	York
	`	how		10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
12	3	with the Maryland a or 28s-f ehow Le notified at	Funeral Director	MD Worceste	r	Ocea	n City				1 ☐ Yes 2x No
2,6		or 2	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
212	2	s 23a	ra	10363 New Quay Ro				21842		USA	
	-1	item item	-in	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Spe ban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ncan Indian, a, etc.
31	99	urs aff	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:	1	☐ Yes 2🌠 No	Specify:		Specify: whi	te
2016: 7/33/193	5-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ehow digal Examirant nual be notified at	To Be Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occu	pation	166	. Kind of Business/I	ndustry unk
0	2121	- CONT.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use retir	e during most of workii ed)	79		
0	CA	be filed withir ital Hygiene. Id other than event, the My	ပိ	12	0	secr	etary	T			
7	anc		Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maio	,	
9	ž	hould to market	2	Joseph Agustos Ma 19a. Informant's Name/Relationship (T)		10h Maille	- Add (C4		ata Tina		
2	Maryland	s 1 and 2 should t Health and Mer Item 27 is marke other traumatic		William Pokorny/				ntand Number or Rura Lay Road Oc			
	ē,	tem tem		20a. Method of Disposition		Place of Dispos	ition (Name of	. D	State of the state	Location - City or 1	
	Ë	000-		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)		cemetery, crem	atory or other pla	ace)		•	
157	Baltimore,	permit. Pag Department Important: h any injury o		21. Signature of Funeral Service licens Ronald 9.	ade, Directo	r St	Name and Addr ate Anat Ltimore,	omy Board	655 W. Ba	altimore S	Street
e		100	Г	3a. Part1. Inter the diseas , or compleshock, in heart failure. List only or	ications that caused the dea						Approximate
1	.0	Physician		Immediate Cause (Final disease or condition	no cause on each line.	ia					Interval Between Onset and Death
8		/Medical		resulting in death)	Due to (or as a conse						
1		Examiner		Sequentially list conditions	end stage	chron	z obstro	uctive puln	ronary o	lisease	
9		pe is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a coose	quence of):			5		
#		ecute and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	iguance of):					
55	90	ate be executed hysician and the burial-transit	cal E		200 10 (01 23 2 001130	iquunica or).					
V /		tificate ng phys as the	-		1						
-9	Вох	eath certifica attending ph for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr					23d. Date of deliv	/en/
4	m.	that the death certifics ed by the attending ph detached for use as t	Physician/Med	in the past 12 months?	1☐Live birth 2 ☐ Fet 4☐Pregnant at time of		Ectopic pregnanc Other (specify) _	гу		Month	Day Year
5	P.O.	at the d by the tached	hys	9 🗆 Unknown	9 Unknown						<u> </u>
_		requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause gr	ven in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
5	Vital Records,	equir en si ould						 	1 🗋 Yes	2 □No 3 □ Pro	bably 4 🗀 Unknown
D	ပ္မ	law r las be 2 sh	Completed						24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
2!	<u>~</u>	The zate h	5						performed	? death?	
	<u>=</u>	Physician: this certifica ral director, J	Be	25. Was case referred to medical examiner?				26. Place of Death	Water Hiller Hill		
2:	5	Physi this o	မှ	1 105 2 100		ER/Outpatient	3 DOA			6 ☐Other (Speci	fy)
Korny,	Division of	ath. r: After re funer	lon	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		8d. Describe how in	njury occurred	
关:	<u>s</u>	death death ctor: y the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome farm stre]Yes 2 □No	8t Location (Street	and Number or Rur	al Bouta Number
\mathcal{L}_{i}	2	pital or A	Certification:	4 Homicide determined	building, etc. (Spec	ify)	et, lactory, office	-	City or Town, St	ate)	ar Houte Number,
		Funda Tely tely	Medical (29a. Certifying Physical Certifying Physical Examination (Chinack Only one)	sician: To the best of my kn ter: On the basis of examin and manner stated.	owledge, death ation and/or invi	occurred at the trestigation, in my	ime, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	o(s) and manner as s and place, and due t	stated. o the cause(s)
		To the within 2 To the comple	Me	29b. Signature and title of certifier	/		29c. Licen	se number	29d. I	Date signed (Month,	Day, Year)
				Up ran Egr	nond Mo		DO	056307	Dec	ember 1	3,2006
_				30. Name and address of person who co	A 4 1 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	т 23а) (Туре, Р	rint)		/	8 2 W	3,2006 ,MD 21811
				J. Van Egmond	MD, Atlanti	z Genera	d Hospit	11, 9733 4	ealthway	Dr., Berlin	,MD 21811
		Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature (de		0		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month December 16, 4:00 A. 2006 William Lanning Ray Jr. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 □ F 215-26-3011 86 Director January 24, 1920 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Damascus 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 25124 Oak Drive U.S.A. or items 23a 20872 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itement illy or other traumate. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW I I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Gasoline Station 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lanning Ray Janie A. Riggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25000 Oak Drive, Damascus, Maryland Sharon Ann Ray / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 12/17/06 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home 23a. Part. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. 20872 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) 5chemic Cardiomy opethi **Physician** YPall /Medical Examiner ean rorenau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) the ettending physicien P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Unknown 1 Tyes 2 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident To the Hospital or Attendition 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 - Homicide t Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 64279 12-16-06 ; 15275 Shady Grove Rd, Ste 201; Roch willt, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20+1 Michae S. Chen 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 1 8 2006 Registrar

			1 - For State Registrar		of Marylar				ealth a Death	nd Me	-	giene Reg. No.	006	40	213
	Physici /Medic		1. Decedent's Name (First, Middle, La Margaret	A. Robe							Date of De Month ecembe		, 2006		e of Death
	Examin Funeral	er	4a. Facility Name (If not institution, giv Glade Valley Nursing a 5. Social Security Number 6. S	ind Rehab	7. Age (In yrs.	last birthday		Walk	Location of Cersvi	.11e	. Date of Birt (Month, Da	F	County of Dearederic	ck	ite or Foreign
	Director Mog		213-24-2797 Usual Residence of Decedent 10a. State 10b. County	□M 2⊠F	78	Yrs. ity, Town or L		Days	Hours	A.	pril 3	, 19	28 Was	hingto	e City Limits
aitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinar must be notified at once.	To Be Completed by Funeral Director	Maryland Frede: 10e. Street and Number 4029 Araby Church 11. Marital Status 1□ Never Married 2□ Married 3⊠ Widowed 4□ Divorced 15. Decedent's E (Specify only highest grave) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last, James A. Hamilton 19a. Informant's Name/Relationship (Helene A. Dieffen) 20a. Method of Disposition 1□ Burial 2□ Cremation 3□ 4□ Donation 5□ Other (Specifications) 21. Signatus of Funeral Service Ligger 21. Signatus of Funeral Service Ligger	Road 12. Was Dec Armed F 1 Yes G Year or C Vication	2 M No ve allows: 1-4or 5+) Ster State	J.S. 13. 16a. Dece (Give life). 19b. Maili 4029 Place of Dispremetery, cre-	Was Deccellif Yes, sport of the Personal Person	dent of Hiscify Cuba 2 No al Occupant done of se retired. S (Street a Chume of other place)	Specify: ation 18. Mother Heler and Number rch Rc 19) De	of working 's Name (for A. or Rural Food, Date cemb 9, 20	fy Yes or No can, etc.) First, Middle, Lechli Route Number Freder e er 06	16b. Kin Maiden der r. City or 1ck, 20c. Loc Rock	Town, State, Mary1 cation - City or	ountry? eS erican India te, etc. ite //industry Zip Code) and 2: Town, State Mary.	1704 Hand
	Associated by Secreted Associated	Ilcal Examiner	23a. Part1. Enter the disease. I com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dications that one cause on a Lu Due to	M014 caused the dealeach line. ng Canc (or as a consection as a consection)	th. Do not en er quence of):	ockvi	lle,	Maryl	Land	20850-	-2805	rey Fu gomery	Approxi Interval	nate Between nd Death
C. BOX 6	death certific e attending p d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live I	tcome of pregn birth 2 Feta nant at time of c own	al déath 3[⊒Ectopic p ⊒ Other (s					2	3d. Date of de Month	livery Day	Year
Records, P.	The faw requires that the de site has been signed by the a bage 2 should be detached f	Completed by Pr	Parli. Other significant conditions of Parkinsons Dementia		eath but not res				n in Part I.		1 □ Y 24a. Whas a autop perfor	es 2 k	death?	robably 4 utopsy findir completion	Unknown
DIVISION OF VITAL M	ng Physician: ifter this certifice ineral director, p	Certification: To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be	28a. Date (Mor	of Injury th, Day Year)	28b. Time o	of M	28c. Injury Work 1 🔲 Y	n. 4図 Nurs	sing Home 280	d. Describe h	ne/ lence 6 ow injury	□Other (Spe		
2	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	cal Certifi	4 Homicide 4 Homicide 29a. Certifier (Check only 2 Medical Exam	build	of Injury - At hing, etc. (Special	fy)	h occurred	at the tim	e, date and	place and	City or Tow	n, State)	Number or R	ctated	
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	and man	ner stated.		29	i, in my op c. License D265	number	occurred		29d. Date	signed (Mont ber 14	h, Day, Yea	r)
10	Sta Registr	te	30. Name and address of person who Allen Gilson, M.D. 31. Date filed (Month, Day, Year) DEC 1.8	1475 32.F	Taney A	venue,	#204		ederic	ek, Ma	arylan	d 21	702		

06-09487 Leo Rites

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

eo Riies		State of Maryland 1- For State Registrar	•	nt of Health an te of Death	id Mental H		g. No. 200	c 1,0211	
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last) LEO		ITES		2. Date of Death Month December	Day Year	3. Time of Death 1226 hrs	
		4a Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Deatl	1	
Funeral		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birtho	Laurel day) If Under 1 Yea	ar If Under 24Hrs	8 Date of Birth	Prince George		
Director		UNKNOWN 1XM 2F	59	Yrs. Months Day		_	Foreig		
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit							
Maryland 28a-f show 1 at once,	ctor	UNK. UNK. UNKNOWN 10e. Street and Number 10g. Citizen of What						1 Yes 2 No	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	al Director	UNKNOWN 11. Marital Status 12. Was Decedent	Ever in II S	13. Was Decedent of Hi	UNK.			USA	
death w or items	Funeral	1 X Never Married 2 Married Armed Forces 1 Yes 2		If Yes, specify Cuba			White, etc.	icari indiari, biack,	
	à	Widowed 4 Divorced If Yes, Give Year or Dates: 15 Decedent's Education (Specify only highest grade con	npleted) 16a. De	1 Yes 2 X No	specify ation (Give kind of v	work done	Specify: 16b, Kind of Business/	WHITE	
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	Iring most of working life	e. DO NOT use reti	red)	LINUZNOUN	,	
215-0036 be filed within tral Hygiene *ked other tha ent, the Medic	Juo.	11 17. Father's Name (First, Middle, Last)		UNKNOWN	18 Mother's Name	e (First, Middle, M	UNKNOWN aiden Surname)		
21215-0036 July be filed within 72 Mental Hygiene marked other than c event, the Medical	Be	UNKNOWN			PAULIN			JACOBI	
MD 2 td 2 shoul ulth and M m 27 is m aumatic	5	19a. Informant's Name/Relationship (Type, Print) RENEE FELLER C/O JEWISH LE		Mailing Address (Stree				RE, MD 2121	
Fe, s l ar of Hea If iter		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from St.	20b. Place of I crematory	Disposition (Name of ce y or other place)	emetery,	Date	20c. Location - City or	Town, State	
Pag ment ment tant:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	BALTIMO	ORE HEBREW 22. Name and Addres					
Balt permit Depart Impor injury		Robert James	>	8900 REI	STERSTOW	N ROAD -		5., INC. E, MD 21208	
Physician /Medical		23a Part I Enter the disease, or complications that caused failure. List only one cause on each line.		enter the mode of dying.	, such as cardiac o	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death	
Examiner		or condition resulting in death) Due to (or as a consequence of):							
	je.	Sequentially list conditions, if any, leading to immediate b. Perforated Descending colon Due to (or as a consequence of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	equence of):			-			
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60, ate be enthysiciar he burial		UNPENDED AMENDED IF FEMALE: 23c. If yes, outcore	ne of pregnancy			_	23d. Date of delivery	,	
certif		23b. Was decedent pregnant in the past 12 months?	time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	ancy		Day Year	
Box 687 he death certific the attending p	Physician/								
ires that the signed by	ğ	Part II. Other significant conditions — contributing to deat	n but not resulting in	n the underlying cause	given in Part I.		eacco use contribute to 2 ✓ No 3 Prob		
ords, w require s been si	Completed	24a Was an 24b We autopsy pric						topsy findings available completion of cause of	
tal Reco cian: The law certificate has	gmo					perform 1 Y Yes 2	ned? death?		
Vital ysician: his certifi director.	a	25. Was case referred to medical examiner? 1 Vos 3 No.	ant 2 EP/Outt	26 Place	Other		Residence 6 Other		
of Viring Physical After this funeral dir	٦: ا	27. Manner of Death 28a Date of Inju			ıry at Work?		ow injury occurred		
Division of Vital Records, talor Attending Physician: The law requirins after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	catio	2 Accident Investigation							
Division pital or Attencours after death teral Director:	ertifi	3 Suicide 6 Could not be determined (Specify)	jury - At nome, fam	n, street, factory, office b	building, etc.	or Town, Sta	reet and Number or Ru ate)	ral Route Number, City	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for 1	Medical C	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
£ ≅ £ 8	Me	and manner stated 29b. Signature and title of certifier		29c. Licens			29d. Date signed (Mor	nth, Day, Year)	
		anel C	tooth (Hear CO)	O.C.	M.E.		December 13, 20	006	
7		 Name and address of person who completed cause of d Ana Rubio MD. Assistant Medical Exam 	` '	enn Street, Baltimo	ore, MD 21201				
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Regular	r's Signature	Sand's					
DHMH 17 Rev 1/2			ORIC	GINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 11:30PM Marie Alice Robertson Dec ii. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death AGNES BALTIMORE, MD. HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 6, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🛱 F 75 Yrs. Director 578-36-8679 Ohio Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ir then "netural", or Iteme 23s or 28e-f ehow the Medical Examinar must be notified at 10d. Insida City Limits MD Anne Arundel Glen Burnie 1 ☐ Yes 2√ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7900 Benesch Circle #789 iiii. Peges 1 and 2 should be filed within 72 hours after death varintent of Health and Mental Hygiene.
The marked other then "netural", or Iteme 23s returns if Item 23s returns it is the Mental injury or other treumatic event, the Mental Esterument and any or other treumatic event, the Mental Esterument and any or other treumatic event, the Mental Esterument and any or other treumatic event, the Mental Esterument and any or other treumatic event. Funerai 21061 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ᇫ 1 ☐ Yes 2X No Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 waitress restaraunt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be Carl Lysikowki Nina Marie Brickey Zizzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Agnes Hospital 900 S. CAton Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ∑Donation 5 ☐ Other (Specify) permit.
Departn
Imports
any nlt 21. Signature of Euneral Service Rel 13 TC ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street lun Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY Unknown /Medical Due to (or as a consequence of): Examiner OPD Unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ettending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death ed by the e 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 2 No 2 No 1 ☐ Yes ours after death.

Nerel Director: After this certific filled in by the funeral director. 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital or 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number

Registrar DHMH 17 Rev 1/2001

State

HAFSA

31. Date filed (Month, Day, Year)

DEC

6

2006

Robertson,

mile

M.D.

CATIN AVE.

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900

P20659

BALTIMOREIMD. 21229

			1- For Amend item#10b-	State of Maryla c, perAB, G862,	nd / Depa 12/16 /0 6	artment of H	lealth and Death		ene g. No. 200	6 40216	
			Decedent's Name (First, Middle, Last)					2. Date of Death)	3. Time of Death	
-	Physici /Medio		Howard L. Ramsey					Month December	Day Yea 6. 2006	10:20 AM	
9	Examir						Location of De	eath	4c. County of De		
			232 Summit Avenue #B Hagerstown						Washington		
	Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 1 M 2 F 60 Yrs.				If Under 1 Year Months Days	If Under 24 H Hours M	lin. (Month, Day,	4015			
			213-44-3103 Feb 23, 1946 Usual Residence of Decedent						1946 De	laware	
	ylanc how		10a. State 10b. County W	eshington 10c. C	City, Town or Lo	ocation Hager	stown			10d. Inside City Limits	
	e Ma	Director	MD Frederick -Frederick 1 Yes 2 No								
	ith th		10e. Street and Number 10f. Zip Code 10g. Citizen of						g. Citizen of What	Country?	
	s 23e	rai	232 Summit Ave				1740		USA		
	ltem Item	Completed by Funeral I	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.	
980	urs af		3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	IT Y 05, GIV0		Specify:		Specify: W	white	
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Maryland 21215-0036	be fill d off	To Be	17. Father's Name (First, Middle, Last)					lame (First, Middle, M	•		
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<u>≅</u>	d 2 s th an traul		Alwine Ramsey/sp					Rural Route Number, B Hagerstow	•		
ē,	tem (20a. Method of Disposition		Place of Dispo	sition (Name of		_	Oc. Location - City of	1740 or Town, State	
Ē	Pages entoi nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specify		cemetery, cren	natory or other place	9)		,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28e-f ahow any injury or other traumatic event, the Madical Examiner must be notified at ance.		21. Signature of Funeral Service Licen	see CMI	22	. Name and Addres	s of Facility				
00	Depermine Deperm		James 1	recto		ate Anato Itimore,	omy Boa; MD 212	rd 655 W. 1 201	Baltimore	Street	
			23a. Part 1 Enter the disease, or companies or heart failure. List only	plications that caused the dea	ath. Do not ente	er the mode of dying	g, such as card	ac or respiratory arres	it,	Approximate Interval Between	
2-	Physician		Immediate Cause (Final disease or condition The Conset and Death Disease or condition The Conset and Disease or condition The								
*	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		3				
	2.44.11.11.01	_	Sequentially list conditions,	· Hejasta	MC N	Ohsmall	coll	mil Cana	65		
	nsit	Examiner	if any, feading to immediate cause. Enter Underlying Cause (Disease or injury								
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9	ng ph as th	Med	IC ECHAIC.								
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						1	23d. Date of delivery Month Day Year	
o.	the a	sici							Month		
<u>.</u>	that the de led by the detached	F		ontributing to death but not re	sulting in the ur	aderhina cauca ava	n in Dart f	23a Did toba	and the contribute	to the course of death?	
Records,	uires tha signed Id be del	d by						and .	23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
ဂွ် ပ	w requ	Completed							^		
Re	The lay cate has page 2	mc						24a. Was an autopsy performe	d? death?	utopsy findings available completion of cause of	
Vital		0	25. Was case reterred to medical				26 Diago of D	eath (Check only one)	(No 1 □ Ye	s 2□No	
	ysicia iis cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient	Otho	_		ome 5 A Residence 6 □Other (Specify)		
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending						d. Describe how injury occurred		
<u>S</u>	uttendii death. ctor: A y the fu	catio	2 ☐ Accident investigation	M 1 Tyes 2 No							
A Homicide determined building, etc. (Specify)							28f. Location (Stre City or Town,	n (Street and Number or Rural Route Number, Town, State)			
_	pital		29a. Certifier Continue Control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	24 h 24 h Fun etely	Medical	(Check only 2 Medical Exam	iner: On the basis of examinand manner stated.	ation and/or inv	estigation, in my opi	e, date and pla- inion, death oc	ce, and due to the cau curred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and control one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner stated. 29b. Signature and title of certifier 29c. License number								290	. Date signed (Mon	th, Day, Year)	
100626A							.607 De	7 December, 11, 2006			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								-3-11.	21740		
			HINGIG HUI	F-ONJOIAC	SPIN	11, ASO.	30 Ut	THE COU	RT, Hage	BSLOMO KD	
	Sta Registra		31. Date filed (Mpnm, Cay, Year) 201	32 Registrar's Sign	ature Ana	A. s			, ,		

06-09489	
Darius Sydnor	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygione

System of the Maryland Physician of the Mary	PARTUS J. 4a. Facility Name (if not institution, give stree St. Agnes Hospital	SYDNOR		Date of Dea Month		Time of Death			
Director	St. Agnes Hospital	t and number)			r 13, 2006	0325 hrs			
Director	5 0 N 0 0	t and number)	4b. City, Town, or Location of I Baltimore	Death	4c. County of Death				
rland -f show any once.	5. Social Security Number 6. Sex 213-77-0710 1 X M 2 Usual Residence of Decedent	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 2 Months Days Hours 3 2	Min.	Foreig	hplace (State or number) MD			
-f show	10a. State 10b. County	10c. City, Town or L	ocation			10d Inside City Lim			
	p MD	BALT	IMORE	·-·		1 X Yes 2			
ith the Maryland 23a or 28a-f sh notified at once			10f. Zip Code 21216		0g Citizen of What Coun				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene rant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumarite event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 Never Married 2 Married 1 1 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1 1 2 1	rmed Forces? Yes 2 X No Give Year as:	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi		White, etc.	ACK			
5-0036 ed within 72 hours sygiene other than "natur the Medical Exami	15. Decedent's Education (Specify only high Elementary/Secondary (0-12) Co	est grade completed) 16a. Dec	edent's Usual Occupation (Give kining most of working life. DO NOT us		16b. Kind of Business/Ir	idustry			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	FRANK SYDNOR		18.Mother's N	Name (First, Middle, N					
MD 21 ad 2 should of the and Me m 27 is ma aumatic ev	.1. To all	1.7	ailing Address (Street and Numbe 9 ELLAMONT ST.	r or Rural Route Num					
ore, ME es l and 2 s of Health at If item 27 her trauma	TRACY ALLEN/MOTHER 20a. Method of Disposition 1 Burial 2 Cremation 3 Rer	20b. Place of Di noval from State crematory	sposition (Name of cemetery, or other place)	Date	20c. Location - City or 1	Town, State			
Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr	4 Donation 5 Other Specify: 2 Signature of Funeral Service Licensee				BALTIMORE,	MD S F.H.,IN 21217			
Physician	23a Part I. Enter the disease, or complication	s that caused the death. Do not en	1701-31 LAURENS ter the mode of dying, such as card		,,	Approximate Inter			
/Medical Examiner		den unexplained dea	th in infancy			Between Onset an Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last									
cuted nd transit	events resulting in death) Last Due to	(or as a consequence or)							
760, icate be executed physician and the burial - transit	X AME	#5,perff, 23a,P.	II,27,28a-f, perME,	g864, 2/2/07	TT				
b. Box 6876 the death certificate by the attending phy ched for use as the Physician/M	TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy Live birth Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pro Other (Specify)		23d. Date of delivery Month Da	ay Year			
P.O. E es that the d igned by the or detached by the or detached by the or detached by the or detached by Physical		outing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?			
cords, law requir has been s 2 should t				24a. Was a autops perform	an 24b. Were auto sy prior to co med? death?	opsy findings availab mpletion of cause of			
ital Recision: The scentificate irector, page	25. Was case referred to medical examiner?	1 Inpatient 2 ✔ ER/Outpat	26.Place of Death (Ch		D				
ding Physi After this funeral dir	1 ✓ Yes 2 No 27. Manner of Death 28.	a. Date of Injury (Month, Day, Year) 28b. Time			Residence 6 Other:				
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Division or Hospital or Attending 24 hours after death Funeral Director: After tely filled in by the funeral Certification:		e. Place of Injury - At home, farm, pecify) House		Baltimore	treet and Number or Rura (ate) 1319 Ellamon (ate) MD	nt St.			
To the Howithin 24 F. To the Funcompletely	(Check only 1 Certifying Physician: To one) 2 Medical Examiner: On the	basis of examination and/or inves	ccurred at the time, date and place, tigation, in my opinion, death occurr						
To To Con	29b. Signature and title of certifier	anner stated	29c. License number O.C.M.E.		29d. Date signed (Monti				
The same	30. Name and address of person who completed Pamela E. Southall, MD Assis	ed cause of death (Item 23a) stant Medical Examiner	111 Penn Street, Baltimore	MD 21201					
State		32 egistrar's Signature	TITE CHIT SHEEL, DAILIFIOR	-, IVID 2 12U I					
Registra	DEU 1 8 2006	Aloqua &							

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		Please Type or Print in State of Maryla				-	_						
		1 State Registrar		ertificate of		Reg.	0000	1.0218					
HEN EE	yr.	Decedent's Name (First, Middle, Last)		-		2. Date of Death		3. Time of Death					
Physici /Medic		30HN S	VEC			Month	Day Year 200	6 2:37 AM					
Examin		4a. Facility Name (If not institution, give street and number)	0 - 0	4b. City, Town, o	or Location of Death		4c. County of Dea						
<u>. New 200</u>		JUHNS HIPKINS BAYVIEH MED 5. Social Security Number 6. Sex 7. Age (In y)	rs. last birthday	D4(5) If Under 1 Year	If Under 24 Hrs.	9. Date of Birth	-	IMORE					
Funeral Director		212-44-8773 15 M 2 F 61		Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry) unk					
h 6		Usual Residence of Decedent				July 29,	1945						
arylan show	_	10a. State 10b. County 10c. (City, Town or t					10d. Inside City Limits					
he Ma Ba-f s	ecto			Baltimore	<u> </u>			¹ X Yes 2 No					
with t	Funeral Director	100. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?					
Jeath	era	1300 S. E11wood Avenue 11. Marital Status unk 12. Was Decedent Ever in Armed Forces?	U.Sunk 13	. Was Decedent of F	L224 Hispanic Origin? (Spec	cify Yes or No-	USA 14. Race - Ame	erican Indian,					
after o		1 ☐ Never Married 2 ☐ Married				Rican, etc.)	Black, Whi	te, etc.					
id K I K I 3-0030 filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □ Yes 21∏ No	Specify:		Specify:whi	lte					
72 h 72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	ı (Giv	edent's Usual Occup e kind of work done	during most of working	unk 16b	. Kind of Business	/Industry unk					
within ene.	Ę	Elementary/Secondary (0-12) College (1-4or 5+) unk unk	ine.	DO NOT use retire	<i>a)</i>								
filed Hygi Sther ent, ti	Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name	(First, Middle, Maid	len Surname)	unk					
If \$\partial \partial							dirk						
and Men is marke	_	19a. Informant's Name/Relationship (Type. Print)	19b. Mai	ling Address (Street	and Number or Rura	Route Number, Cit	y or Town, State,	Zip Code)					
and and and and and and and and and and		Hopkins Bayview Med Ctr			Avenue Bal		MD 21224	<u>′+</u>					
ges 1 tof H if iter or oth		20a. Method of Disposition 20b 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	o. Place of Disp cemetery, cr	oosition (Name of ematory or other pla	ce) Da	ate 20c	Location - City or	Town, State					
Dalkillion Pages Pepartment of mportant: If it iny Injury or o		4□Donation 5☑Other(Specify) in state		20.11				<u></u>					
partilliore, Ivid permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau	П	21. Signature of Foneral Service Licensee Ronald S. Waste Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
		23a. Part . Enter the diseas , or or mp loations that caused the de short, or heart failure. List only one cause on each lin.						Approximate					
Physician		Immediate cause (Final	TS					Interval Between Onset and Death					
/Medical		disease or condition resulting in death) a. Due to (or as a cons.)	sequence of):										
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be ex ician a		Due to (or as a consi	sequence or):										
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ath certi	N.	IF FEMALE: 23c. If yes, outcome pf pregant					23d. Date of de	livery					
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by the	hys	9 ☐ Unknown											
es tha	by F	Part II. Other significant conditions contributing to death but not re	resulting in the	underlying cause giv	en in Part I.			the cause of death?					
w requires to been signer should be o						1 Yes	2 No 3 P	robably 4 Honknown					
e 2 sh	Completed					24a. Was an autopsy	prior to	utopsy findings available completion of cause of					
r. The icate						performed 1□ Yes 2 🗷	death? No 1 ☐ Yes	2 □ No					
Siciar certif	Be	25. Was case referred to medical examiner?		ont 3 DOA Oth	26. Place of Death								
Phys er this	5	27. Manner of Death 28a. Date of Injury	ER/Outpatie	all DOA	4 L. Nursing Hor	e 5 Residence		cify)					
arth.	tiol	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation) Injury		k? Yes 2 □ No								
Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spe	t home, farm, s	treet, factory, office	21	Bf. Location (Street City or Town, St	and Number or Ri	ural Route Number,					
ital or ral Dil	Cerl					ony or rown, or							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affact death. To the Funeral Director: Attentials certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Check only 2 Medical Examiner: On the basis of exami	knowledge, dea ination and/or i	ath occurred at the ti	me, date and place, a opinion, death occurre	nd due to the cause ed at the time, date	(s) and manner as	s stated.					
thin 2 the 1 the 1 mplet	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens			Date signed (Mont						
5 ¥ 5 8		1/2Kel De	<u>r</u>			230.1	Jate signed (World	n, Day, Year)					
		30. Name and address of person who completed cause of death (lit	tem 23a) (Type	Print)	5-000		120/10	0					
			940 8	ASTERN	AVENUE	BAITA	MORS	M7) 21226					
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sig	gnature	150	7-7-	- /		, , , , , , , , , , , , , , , , , , ,					
Registr		DEC 1 6 2006	36 1	1000									
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			1 - For State Registrar	State of M	larylan		artment <i>tificate</i>			Mental H	ygiene Reg. No	_ 0 0 0	40	219
	Physici: /Medic		1. Decedent's Name (First, Middle,	Last)	ST	ERSHI	C			2. Date of I Month	Da	y Year	r	ne of Death
_	Examin Funeral		4a. Facility Name (If not institution, 5417 Knell Aver. 5. Social Security Number	iue 6. Sex 7. Ag	ge (In yrs. I	last birthday)	Balt:	imore	Jnder 24 Hrs	8. Date of E	Birth	. County of De	irtholace (St	ate or Foreign
	Director		214-22-5254 Usuel Residence of Decedent	1□ M 2\\ X F	80	Yrs.		Dayo		Nov. 1	$\stackrel{Day, Year}{1}, \stackrel{Year}{1}$	926 Ma	ssáchi	issette
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							de City Limits
	Ba-f s	ctor	MD		Bal	timore								Yes 2□No
	with ti	Dir	10e. Street and Number 5417 Kne11 Aver	1116			10f. Zip C	206				tizen of What ($\mathbf{5.A.}$	Country?	
200	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. The filem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent	?	l I		nt of Hispar y Cuban, M	nic Origin? (S lexican, Puer pecify:	Specify Yes or I to Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc. Specify: White			n,
213-0	ithin 72 hou ne. nan "nature Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give life. £		Occupation done durin retired)	g most of wo	orking		(ind of Busines	s/Industry	
7	iled w dygier ther th		12th grade 17. Father's Name (First, Middle, La	ast)		Accou	nting	18	Mother's Na	me (First, Mida		airy		
	id be f ental h ked of ic sve	o Be	Edmond Canvel	isty				10.		Chevrie		, gamamo,		
Maly	nd 2 shou eith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship Beorge Stershio							ural Route Num 1timore		or Town, State, 21206		
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חשור	permit. Departr Imports any inju		21. Signature of Funeral Service Li			6	Name and	elair	Road,	iller-D Baltim	ore,			ne, Inc 1206
Ī	-		23a. Rart1 Enter the disease, or conshock, or heart tailule. List or	omplications that cause nly one cause on each I	d the death line.	n. Do not ente	er the mode	of dying, su	ch as cardia	c or respiratory	arrest,			imate I Between and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- BREAK	ST CA	<i>tncer</i>							8 M	SHTE
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	ecuted and transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):												
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	ath certii ttending or use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	death 3	Ectopic pred Other (spec				23d. Date of delivery Month Day		Year		
600	w requires that the de been signed by the a should be detached f	by	Part II. Other significant condition	s contributing to death t	but not resu	ulting in the un	iderlying cau	ise given in	Part I.			use contribute		e of death?
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A 10	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Other		ath (Check only				
5	ng Phy fter this ineral c	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju	ury	ER/Outpatient 28b. Time of Injury		c. Injury at Work?		10me 5 Re 28d. Describe			ecify)	
i A	To the Hospital or Attending Physician: within 24 hours alter death To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	ijury - At ho tc. (Specify	me, farm, stre					(Street an own, State	nd Number or F e)	Rural Route	Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											se(s)
	withii To th	M	29b. Signature and title of certifier	/				License nur				te signed (Mor	-	
	3		30. Name and address of person with	ho completed cause of	death (Item	23a) (Type, F	Print)	620	32	-CLE,	DECE	EMBER	15 2	006
	-		JENNIFER HAYA	5H1 550	OS Cinna	HOPKII	US BY	AYVIE	W CIR	-CLE,	BAC	TIMORE	MD	21224
	Sta Registr		31. Date filed (Month, Day, Year)	100	rar's Signat	ture	الاعظام							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Christos L. Stratakos 17, 2006 /Medical Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner Bny nit If Under 1 Year Months Davs If Under 24 Hrs. 8. Date of Birth Aug 1, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Hours Min. Stefania, Greece 212-70-9900 83 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X☐ No MD Anne Arundel Hanover 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1472 Mordor Lane 21076 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural" or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Securius, 12th grade ntary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonidas Stratakos Florentia Manolakos ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1472 Mordor Lane, Hanover, Maryland Effie Stratakos, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State Oak Lawn Cemetery Dec 19, 2006 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles Zeiler Funeral Home, Inc Eastern Avenue, Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Uist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Dav Year 5 Other (specify) 1 Yes 2 No 9 Unknown page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy perfor 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No Medical Certification; To 1 Dipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After T Natural (Month, Day Year 5 ☐ Pending investigation death. 2 Accident 1 🗌 Yes 2 No within 24 hours atter death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

egistrar's Signature

OP

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of H rtificate of L	lealth an D <i>eath</i>	d Mental Hyg	ienez 0 0 (5 40221			
			1. Decedent's Name (First, Middle, Last,)				2. Date of Deat	th	3. Time of Death			
	Physici /Medi		Geraldine A. S	heridan				Decembe	er 13, 200	1			
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of D		4c. County of De				
			Brighton Gardens			Betheso	la		Montgom	orv.			
	Funeral		5. Social Security Number 6. Set	7. Age (i	In yrs. last birthday,	If Under 1 Year Months Days	tf Under 24 I	Hrs. 8. Date of Birth Ain. (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)			
В	Director		100-14-0493	JIVI ZENF	85 Yrs.			Oct. 8,	1921 Ne	w York			
	and *		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or L	ocation				10d. Inside City Limits			
	f ehc	ō	Marry land Mantager							1 ☐ Yes 2 No			
	288 288	Director	Maryland Montgome 10e. Street and Number	гу	North Bet	10f. Zip Code		1	0g. Citizen of What				
	3a or	₫	5550 Tuckerman Lan			20852			United States				
	ms 2	era		12. Was Decedent Eve		Was Decedent of Hi	spanic Origin	panic Origin? (Specify Yes or No- 14. Race - American					
٥	or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cuba	n, Mexican, Pi	uerto Rican, etc.)	Black, Wi	nite, etc.			
3	ref. c	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/ No	Specify:		Specify: W	hite			
ה	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28s-f ehow ha Madical Exercities mast be notified at	Completed by Funeral	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occupa	furing most of	working	16b. Kind of Busines	ss/Industry			
7	of thin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired,)						
7	Hygie otherti	ပိ	17 Fabrus None (Fine Middle 1 and	2	Sec	retary			Real Es	tate			
בב	be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, M	Maiden Sumame)				
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Maryland 21215-0036	h and h and h and h and h and h		19a. Informant's Name/Relationship (Ty	H1001-21	1			Rural Route Number,					
<u>က်</u>	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28a-f ehow or other traumatic event, the Madical Examinating in at its profiled at		Patricia A. Pritchard/Daughter 20716 Boutyfield Place, Montgonery Villace, Managery										
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	it. Purtme		4 Donation 5 Other (Specify)		` Ce	metery	19	2006	Triangle,	Virginia			
g	Dermi Depa Impo eny ir		21. Signature of Funeral Service Liberise		K	ockville,	Inc.	300 West	Pumpnrey Montgomer	Funeral Home/			
			23a Part Fotor the disease or compli	Montgomer -2805	Approximate								
			shock, or heart failure. List only one cause on each line. Interval Onset										
	Physician /Medical		disease or condition resulting in death)	Sepsis									
	Examiner		Due to (or as a consequence of): Urinary Tract Infection										
		Examiner	Sequentially list conditions,	b. Urinary Tract Infection Cus to (or as a consequence of):									
	uted I Insit		Tary, leading to iningulate cause. Enter Underlying Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events Cause (Disease or injury that initiated events										
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Q	iffical as th	led							100				
POX	death certificate be executed e attending physicien and id for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		23d. Date of d	elivery							
	the att	Sicient	in the past 12 months? 1 ☐ Yes 2X No	1 Live birth 2 ☐ 4 Pregnant at tim 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year			
5	at the	چ	9 Unknown										
Ś	The law requires that the ate has been signed by the bage 2 should be detached.	þ	Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use contribute	to the cause of death?			
ם ס	w requir been si should I	ted						_ 1 🗆 Ye.	s 252,No 3⊡1	Probably 4 Unknown			
Vital necords,	has b	Completed						24a. Was an		autopsy findings available ocompletion of cause of			
		5						perform	led? death? X☐No 1☐Ye				
= =	ilotan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of [Death Check only one					
	Physi this c	은	10 163 AC 110	ospital:	2 ER/Outpatier		4 X IAUISIII	g Home 5 ☐ Resider		ecify)			
	on of the range of	ö	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Work		28d. Describe how	w injury occurred				
2	death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 □ Could not be				'es 2 □ No						
DIVISION OF	for Att after d Direct Jin by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. (\$	- At home, farm, str Specify)	eet, factory, office		281. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,			
-	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	inian: To the best of				1					
	Hos 24 ha Fun etely	edlcal		ician: To the best of m er: On the basis of exa and manner stated	amination and/or in	estigation, in my opi	e, date and pla inion, death of	ace, and due to the car ccurred at the time, da	use(s) and manner a te and place, and du	as stated. ne to the cause(s)			
	To the Howithin 24 h To the Fur	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,											
	F>F0) Chal	M-0.		D204	20						
	~		30. Na and ddress of person who col		(Item 23a) /Tuno	D301.	3 2	De	ecember 15	2006			
2	-		16. 1				1 D1	ard Ta M	l 1 00	NOEO 20/6			
	Sta	te	Rita Ghosh, M.D. 31. Date 100 (Month, Day, Year)	32#Registrar's	Signature	Control of the second	r, Kock	cville, Mar	ryland 20	J80U-394b			
	Registr	_	DEC 1 8 200	S Produce	H. Son	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 VICTOR SCHORN BAUM 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING 9. Birthplace (State or Foreign Country) HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F 38 816 Director 08 10 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director KENSINGTON MI MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a o COMAS # 201 20895 MSA 3000 AVE Funeral MC 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk un Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ?7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS HOSPITAL 1500 FOREST GLEN RD SILVER SPRING MO 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wad 22. Name and Address of Facility State Anatomy Bo Baltimore, MD 2 Anatomy Board 655 W. Baltimore Street more, MD 21201 23a. Part1. Inter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician PUEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OBSTRAC CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 MELLI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed RETARDAT 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼No page 2 autopsy 1□ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hours a

State

(Check only one)

29b. Signature and title of certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

FOREST GLEN RD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 62520

29d. Date signed (Month, Day, Year)

SPRING

SILVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year -20 A M Deenley 200 6 /Medical 4b. City, Town, or Location of Death et and number) Facility Name (If not institution, gi 4c. County of Death Examiner Healthcar borside timore 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 34-6176 1**X** M 2□'F Days Hours Min Director orth (woll Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ es 2 ☐ No MD timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be in 1239 12. Was Decelent Ever in U.S. Armed Forces? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bace - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ☐ No Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: ac 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Sacondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma Be a 19a. Informant's Name/Relationship (Type. Print Daughter, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. MD21239 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) WINGS MILLS MD 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** love thou /Medical Due to (or as a consequce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Day 4□Pregnant at time of death P.O. the detached 9□Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 2 No Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one Other: 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ballimole 0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

3 Registrar's Signature

			1 - For State Registrar	State of Ma	aryland .				ealth a Death	ind M	ental H	ygier Reg. I	Z 11 11 15	40	1224
	Physic	an	Decedent's Name (First, Middle, La	st)							2. Date of D		Day Year		e of Death
	/Medi		Cynthia H. Tic							Decem		9, 2006		BOP M	
1	Examir	ner	4a. Facility Name (If not institution, given	e street and number)			4b. City,	, Town, or	Location of	Death			4c. County of De	ath	
			Sunrise Assisted					kvill		VI. (C			Montgom		
	Funeral Director		5. Social Security Number 6. S	Dex 7. Ag	e (In yrs. last	Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, L			irthplace (Sta Country)	ate or Foreign
			226-54-9624 Usual Residence of Decedent		_67						June	16,	1939 Ma	ryland	
	yland 10W		10a. State 10b. County		10c. City, To	own or Loc	ation							10d. Insid	e City Limits
	Man	tor	Maryland Montgome	17 (7	Rocky	zi 110								150	res 2 □ No
	r 288	Director	10e. Street and Number	.т. у	TIOCKY	/ TITE	10f. Zip	Code				10g. (Citizen of What C	Country?	
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	deat	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W	Was Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc.			city Yes or N		14. Race - Am	erican Indiar	٦,	
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ano	ntal hed of	Be										e, Maidi	en Sumame)		
2	should be nd Mental marked imatic ev	၉	Raymond Paul Hu 19a. Informant's Name/Relationship (1	Ob. Mailine		/C4			Morse				
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Baltimore,	Pages nent of I ant: If its ary or o		1 XBurial 2 Cremation 3		St. Pe	eter s	atony or o	other place	" D	ecem		Perth Amb		Dy,	,
₽	교육관금 .		4 ☐ Donation 5 ☐ Other (Specification 21. Signalum → Feral Service Lice)	*	Church	n Cemet	en		s of Facility	6, 2	006	Ne	w Jersey	V	
Ba	Depa Impo any l		A	1	M00000						ert A.	. Pu	mphrey 1	unera	1 Home
			23a. Part1. Enter the disease, or com	plications that caused	the death D	Roc	kvil	le,	MD 2	0850	-2805	LIOLI	tgomery	Avenu	e
			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.	0 110(011(0)	1 (110 11100	e or dying	, such as C	ardiac or	respiratory	arrest,		Interval	nate Between nd Death
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Вох	thet the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of									23d. Date of de	livery	
Ω.	deatl e atte	Ca	in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth : 4□Pregnant at			Ectopic pr Other (sp					İ	Month	Day	Year
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ώ.	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting	g in the und	derlying ca	ause giver	n in Part I.		23e. Did	tobacco	use contribute t	o the cause of	of death?
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Division of Vital Records,	tending Physician: The leath. Itel to the funeral director, page the funeral director, page	Bec	25. Was case referred to medical					_	26 Place o	f Death	1 Yes Check only		o TYPE	2 □ No	
>	Attending Physician: r death. ector: After this certific by the funeral director, i	2	examiner? 1 ☐ Yes 2√2000	Hospital:	nt 2 ER/C	Outpatient	3 DO	Other			e 5 ☐ Resi		6 (Stother (Spe	cifu) Ass	sisted
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000	endin	atic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		,,	,,	М		es 2 No						
<u>≅</u>		Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, (Specify)	farm, stree	t, factory	, office		28	f. Location (Street a	nd Number or R	ural Route N	umber,
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	To the Hospital or At within 24 hours efter or To the Funeral Direc completely filled in by			and manner stat	ed.										
	Z Z S	_	29b. Signature and title of certifier	12.1				. License				29d. Da	ate signed (Mont	n, Day, Year,)
	7		- TURK	ww)				D3579	92			December 14, 2006			
1	51		30. Name and address of person who						ъ.	1 . 4					
میں	Sta		Swaroop G. Rao,	M.D. 50 W	est Ed	monst	on L	rive	, Koc	kvil	ie, Ma	aryl	and 208	352	
	Registra			2008		· Lon	all.	3							

		•	1 - For State Registrar	State of Man		artment of		nd Mental Hy	/gieme 0 0 6	40225	
6.	Physici /Medic		1. Decedent's Name (First, Middle, Last Roderick,	B	, Thor				Day Yea	12:07P M	
	Examin	er	4a. Facility Name (If not institution, give GOOD SAMARITAN 5. Social Security Number 6. Se	HOSPITAL	n yrs. last birthday)	BALT			4c. County of De	eath Birthplace (State or Foreign	
	Funeral Director		242 30 5420 15 Usual Residence of Decedent	x 2 F 82	Yrs.	Months Da	ys Hours	Min. 8. Date of Bi (Month, Di JAN • 2		DRTHCAROLINA	
	he Marylar 28a-f show	Director	MD . 10b. County MD . N . A	10	Dc. City, Town or Lo	ALTIMO			10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy njury or other treumatic event, I'm Madical Exabil wir must be notified at anone.	Funeral Dir	1700 MERIDENE 11. Marital Status 1 Never Married 2 Married	DRIVE AP	T.512 r in U.S. 13.		21239 of Hispanic Origin Cuban, Mexican, F	USA			
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2	be filed withir tal Hygiene. d other than	Be Completed	9 TH 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		EL WOR	KER 18. Mother's	s Name (First, Middle		EEL	
Maryland	nd 2 should lith and Men 27 is marke r treumatic	2	DAVID THOMAS 19a. Informant's Name/Relationship (7) MARTHA J. THOM.				eet and Number		per, City or Town, State	o, Zip Code)	
Baltimore,	. Pages 1 authent of Heatent: If Item jury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4	Removal from State	20b. Place of Dispi cemetery, cre ARBUTUS	osition (Name of matory or other MEM • P	place)	Date	20c. Location - City	or Town, State	
Ball	permit Depar Impor any in		2) Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	Dications that caused the			ERAL HOME	proximate Interval Between			
	Pnysician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		onsequence of):	trter	Y Di	sease		Onset and Death	
68760,	te be executed ysicien and te burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a co	betes					2040012	
.O. Box 68	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregna □ Other (specify			23d. Date of delivery Month Day Year		
S, O	The law requires that the deate has been signed by the apage 2 should be detached f	b	Part fl. Other significant conditions co	ontributing to death but n	not resulting in the u	underlying cause	given in Part I.			to the cause of death? Probably 4 DUMKnown	
al Record	ysicien: The law nis certificate has be director, page 2 sh	Completed						24a. Was auto peri 1 🗆 Yes			
Division of Vital	Attending Physicien: or death. ector: After this certifics by the funeral director. (tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 LevOutpatie 28b. Time o Injury	of 28c.	Other	28d. Describe	one) idence 6 □Other (S how injury occurred	pecify)	
Divisi	e gite	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, sf Specify)	reet, factory, offi	се	28f. Location City or To	(Street and Number or Rural Route Number, own, State)		
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	fedical	(Check only 2 Medical Exam	ysician: To the best of n niner: On the basis of ex and manner stated	amination and/or in	nvestigation, in n	ny opinion, death	place, and due to the occurred at the time	, date and place, and c	lue to the cause(s)	
•	To Too	W	29b. Signature and title of certifier Pta F.	King 1	no	D	3715		29d. Date signed (Mo	4,2006	
10	Sta Registi		30. Name and address of person who of the state of the st	completed cause of death CS 32 Registrar's	n (Item 23a) (Type 56	Ol Loc	h Rove	BlvD	Baltimo	re M.D 31239	

06-09158 Robert Bruce Travers

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2006 4022	6 40228
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		1- For State Registrar		Certific	cate of	Death			Re	eg No.	JUD) 4022
Physici	an/	1. Decedent's Name (First, Mic	idle,Last)						Date of Deat			3 Time of Death
Medical Exami	ner	Robert Trave							Month December			2205 hrs
		4a. Facility Name (if not instituted 612 Camden Avenue	_	umber)	ľ	b. City, Town,				4c County of Wicomic		
Funeral		5 Social Security Numberun	6 Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Ye	Salisb ear If Under	r 24Hrs.	8. Date of Bir	th (MM/DD/YYYY	9 Birth	nplace (State or unk
Director		dii	1 X M 2 F	52	Yrs.		ays Hours	Min.	NOv 8		Foreign Cour	1
_	ŀ	Usual Residence of Decedent								,	1	
any		10a State 10b. Count	у	10c. City, Town	n or Locati	on				· · · · · · · · · · · · · · · · · · ·		10d Inside City Limits
Maryland 28a-f show d at once.	ē	MD Wic	omico	Sa	lisbu	ıry						1 Yes 2 X No
Maryl 28a-f d at o	Director	10e. Street and Number				10f. Zip Code			11	Og. Citizen of Wh		ry?
ith the Maryland 23a or 28a-f sho notified at once	اة	612 Camden	_				2180	1		U	ISA	
15-0036 filed within 72 hours after death with the Maryland Hygene ed other than "natural", or items 23a or 28a-f shr i, the Medical Examiner must be notified at once	Funeral	11, Walta Otatao		ecedent Ever in U.S. Forces?unk	15.37	s Decedent of Hes, specify Cub.				- 14. Race White		an Indian, Black,
er dea , or it			1 Yes	2 No	1	Yes $2\overline{X}$ N	lo specific			Specify	wh	ite
ırs aft tural"	d b	15. Decedent's Education (S	or Dates:					kind of wor	k done un	16b. Kind of Bu		
5-0036 led within 72 hours af Hygiene I other than "natural the Medical Examin	Completed	Elementary/Secondary (0-1	2) College	(1-4 or 5+)	during me	ost of working li	fe. DO NOT (use retired	d)			
036 ithin in that r that	Jdm	unk	unk									
5-0 iled w Hygic I othe		17. Father's Name (First, Midd	le, Last)	-		unk	18.Mother's	s Name (F	irst, Middle, N	Maiden Surname)	unk
21215-0036 vuld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be	40 July Mary Balakia	hi- (T D-i-1)	La	Ole Billione	A did (O)			15		61.1	
	ř	19a Informant's Name/Relatio O.C.M.E.	riship (Type, Prifit)	104		enn St				nber, City or Tow $10 - 2120$		Zip Code)
MD and 2 sho lealth and 27 is traumati		20a. Method of Disposition		20b. Place	of Disposi	ition (Name of c			Date .	20c Location -		own, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremate		- Ioni State	atory or oth	ner place)						
Itim ii. Pa artmer ortan	1	Donation 5 X Other 21 Signature of Funeral Serie	Specify: in st	ate	22. N	ame and Addre	ss of Facility					
Balti permit. Departm Imports		Ronald	Sprage	Digector	St Ba	ate Ana Itimore	tomy B	30ard 2120	655 W	. Baltin	ore	Street
Physician		23a. Part I. Enter the disease, failure. List only one caus		caused the death. Do r						est, shock, or hea	art	Approximate Interval Between Onset and
/Medical Examiner		Immediat ause (Final disea		ensive athero	sclero	tic card	iovascul	lar di	sease			Death
ZXammer		or condition in sulting in death	Due to (or as	a consequence of):								-
	<u>_</u>	Sequentially list conditions, if any leading to immediate	b. Due to (or as	a consequence of):								
	ii.	cause. Enter Underlying Cause (Disease or injury that initiated	e c	11171								
sd sit	Examiner	events resulting in death) Las	t Due to (or as	a consequence of):								
760, Teate be executed sphysician and the burial - transit		X UNPENDED	d. X AMENDED			-					\rightarrow	
so, e be e ysicia buria	n/Medical	IF FEMALE:		#4b,23a,27,		G862, 1	2/21/06	TT		23d Date of	dolivos	
8760, rifficate boing physicas the buries as the buries	N/S	23b. Was decedent pregnant in past 12 months?		birth		tal death 3	Ectopic	pregnanc	у	Month	Da	y Year
Box 687 e death certific the attending p	sicie		lalineum -		5 Oth	ner (Specify)						
P,O. Box 68's that the death certiff greed by the attending e detached for use as:	Physicia	Part II. Other significant cond	9 Uliki		na in the H	nderlying cause	alven in Par	rt I	T 23e Did to	hacco use contri	hute to th	ne cause of death?
F.O. ires that the signed by	by	rait II. Other significant con	ations continuing	to death but not resulti	ng in the u	ilderlyllig cause	given in Fai	11.1				bly 4 V Unknown
ords, w requires is been sig	Completed by								24a. Was a			ppsy findings available
COFC law re has be 2 sho	Jple								autop perfor	sy p		mpletion of cause of
tal Rec cian: The certificate ector, page	S								1 Yes		✓ Yes	2 N o
ital ician: s certi	å	25. Was case referred to medi examiner?	Hospital:	Inpatient 2 ER/0	Outpatient		Other	Check onl		Residence 6	Other (0
of Vi Physi er this	잍	1 Yes 2 No 27. Manner of Death			. Time of Ir		jury at Work?			now injury occurre		scene -
Division of Vital Records, tal or Attending Physician: The law requir rs after death all Director: After this certificate has been s led in by the funeral director, page 2 should be	Ö	1 [V] Manual	(Mon ending	e of Injury 28b. th, Day Year)		· · ·	Yes 2			,,,,,		
ivisior or Attend after death Director:	licat		vestigation 28e. Pla	ce of Injury - At home,	farm, stree	et, factory, office	building, etc	c. 28	Bf. Location (S	Street and Number	er or Rura	al Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:		termined (Specify)				- 1	or Town, S	tate)		
Hosp 24 hou Fune tely fi		29a Certifier	Physician: To the be	est of my knowledge, de	eath occur	red at the time,	date and plac	ce, and du	e to the caus	e(s) and manner	as starte	d
To the Hos within 24 h To the Fur	Medical	one) 2 Medical E	caminer: On the basis and manner	of examination and/or stated	investigat	ion, in my opinio	on, death occ	curred at th	ne time, date a	and place, and d	ue to the	cause(s)
F 3 F 3	ğ	29b. Signature and title of cert	fier				nse number			29d Date signe		
		and ?	-			0.0	C.M.E.			December:	2, 2006	;
		30 Name and address of pers				tonat D III	ore MD	21201				
			ssistant Medical		renn S	treet, Baltin	iore, IVID 2	∠12U1		· · · -		
S Regis	tate trar	31 Date filed (Month, Day, Yea	1 6 2006	Registrar's Signature	i fo	and!						
				TY.			_	_				

06-09500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Arthur Veney	R	For State		of Maryland		rtment of tificate of		na Ment		Reg	j. N o.	2006	5 4022		
Physician/ Medical Examine		Decedent's Name (First, Midd ARTHUR L. VE		, JR.		٠				ate of Death Ionth ecember		Year 06	3. Time of Death 2300 hrs		
partie 16-	4	a. Facility Name (if not instituti Future Care Nursing		street and number)		4	b. City, Town, o Randallsto		f Death		4c. C	ounty of Death			
Funeral Director	2	Social Security Number	6. Sex	7. Ag	je (In yrs Ta	ast birthday) Yrs.	If Under 1 Ye Months Da		Min	1					
any	_	Jsual Residence of Decedent 0a. State 10b. County			10c. City,	Town or Location	on						10d. Inside City Limits		
Varyland 28a-f show any 1 at once.	5	MD BALT Oe. Street and Number	mo	RE	RAN	DAUST	10f. Zip Code			110	Citizen	n of What Cour	1 Yes 2 K No		
the Maryland a or 28a-f sh tifted at one			IRCL	Æ			2113	32		100	g. Ollizoi	USA	y ;		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene Inportant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Funeral Director	5	1. Marital Status 1. Never Married 2. 🔍 N		12. Was Decedent Armed Forces'			Decedent of H	lispanic Orig			14		can Indian, Black,		
fter dea	- 1			1 X Yes 2 f Yes, Give Year or Dates:	No	1 🗍	Yes 2 🗶 N	o specify:			Sρ	ecify: BUA	ex		
hours afti 'natural'' Examine		15. Decedent's Education (Sp Elementary/Secondary (0-12				16a. Decedent during mo	's Usual Occup est of working lif			done	16b. Kind	d of Business/I	ndustry		
5-0036 ed within 72 hour lygiene other than "natu he Medical Exan		12 TH GRADE		2 YRS	0.7								COUNTY		
MD 21215-0036 nd 2 should be filed within 7 alth and Mental Hygiene m 27 is marked other than raumatic event, the Medica		7, Father's Name (First, Middle ARTHUR VENE)		3R					s Name (Firs	st, Middle, Ma	aiden Su	rname)			
212 hould be and Ment is mark	2	19a. Informant's Name/Relation	ship (Ty	pe, Print)	19b. Mailing Address (Street and Number or Rural						al Route Number, City or Town, State, Zip Code)				
t, MC and 2 st lealth ar tem 27 trauma		QUEENIE VEN	EY	(WIFE)	20b F	Place of Disposi	tion (Name of c		Da Da			ation - City or	2/133 Town, State		
altimore, rmit. Pages l ar spartment of He prortant: If ite		1 Burial 2 Crematic	-	Removal from St	ale	crematory or oth	•		12.19	.06	RAN	IDALLSTO	WN, ND		
Baltii permit. Departm Importa injury o	1	21. Signature of Funeral Service		9		22. N VA U	ame and Addre	ss of Facility	NEF	UNERA	L SI	ERVICE			
Physician	+:	23a. Part I. Enter the disease, of failure, List only one caus			the death.	Do not enter the	e mode of dying	g, such as ca	PIRE ardiac or res	BAI piratory arres	30. st, shock	MD スに or heart	Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final diseas or condition resulting in death)	e a.F	Pulmonary Through to (or as a cons									Death		
	1	Sequentially list conditions,		Deep Venous T											
i		if any, leading to immediate cause. Enter Underlying Caus	_	ue to (or as a cons	equence of	f):									
ted 1 ansit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):														
68760, certificate be executed nding physician and se as the burial - trans	<u> </u>	UNPENDED		AMENDED											
8760, ifficate be ag physic is the bur		F FEMALE: 3b. Was decedent pregnant in		23c. If yes, outco	me of pregr		al death 3	Ectopic	pregnancy			Date of delivery onth E	y Day Year		
Box 687 e death certificathe attending p ed for use as th	200	past 12 months? 1 Yes 2 No 9 U	nknown	4 Pregnant a 9 Unknown	t time of de	- the	ner (Specify)								
230											the cause of death?				
S, P. Quires the signer of the	ed by								- 1	1 Yes			topsy findings available		
Records, P.O. The law requires that the care has been signed by it page 2 should be detacted.						autops perforn	y n <u>ed</u> ?	prior to death?	completion of cause of						
24a. Was an autopsy performed? 1 V Yes 2 No 25. Was case referred to medical 25. Was case referred to medical 26. Place of Death (Check only one)									1 🗸 Ye	es 2 No					
f Vita	<u> </u>	examiner? 1 Yes 2 No 27. Manner of Death	Ho	ospital: 1 Inpati	ent 2	ER/Outpatient		Other	Nursing Ho	ome 5 F	Residence				
Sion o Mending death. ctor: Afte		1 Natural 5 Pe	nding	(Month, Day,	Year)	200. Time of it	· · _	Yes 2		. Bescribe in	on injury	Cocarroa			
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the total curs after death. After this certificate has been signed by tety filled in by the funeral director, page 2 should be detacted.	Certification.	3 Suicide 6 Co	estigatio uld not b ermined	e 28e. Place of I	njury - At ho	ome, farm, stree	et, factory, office	e building, et	c. 28f.	Location (St or Town, Sta		Number or Ru	ral Route Number, City		
hou hou		4 Homicide 29a. Certifier 1 Certifying	Physicia	ın: To the best of r											
To the Hos within 24 h To the Fun	(Check only only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and only) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated. 29b. Signature and title of certifier 29c. License number									time, date a		, and due to the te signed (Mo.			
Pariet Fruthall MA) O.C.M.E.										mber 14, 20					
7	1	30. Name and a ress of person					1 Don- Ct	ot Dalti-	oro MD	21201	-				
Stat	te	Pamela E. Southall, 31. Date filed (Month) Pay Yea		Assistant Med		ure	1 Penn Stre	et, Baitim	iore, MD	21201					
Registra	ar	31. Date filed (Month Pay Yea	8 2	006	Chillian		3452.3						· · ·		

DHMH 17 Rev 1/2001 OCME 2006

06-09573	
Lerov Williams	

Leroy Williams	1	State of Maryland / Department of Health and Mental H For State Certificate of Death		2000	1.0228
Dhysisis	R	egistrar Decedent's Name (First, Middle,Last)	2. Date of Death	g. No.	3. Time of 0 eath
Physicia Medical Examir		Lek 1.1 71). 30: 1 mg/	Month December	Day Year 15. 2006	1557 hrs
ng para	_	la_Fac_lity Name (if Not institution, give street and number) 4b. City, Town, or Location of Deatl		4c. County of Death	
		303 Maider Choice Lane Apt 323 Catonsville		Baltimore Cou	nty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr			hplace (State or
Director		166-07-7953 1 MM 2 F 86 Yrs. Months Days Hours Mir	Lestel.	0 15 1920 Col	untry) Florida
	P	Jsual Residence of Decedent	Light Conses	2 33 7 7 2 2	
any	Ī	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd show	= K	ARyland Baltimore Catonsville			1 Yes 2 No
laryla	۲ <u>۲</u>	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
with the Maryland is 23a or 28a-f show any e notified at once.	Directo	303 Maiden Choice Lane Apt 323 2/228		USA	
% S €		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Ameri White, etc.	can Indian, Black,
or iten	اڌ	Never married 2 Married 1 X Yes 2 No	o radan, cro.,	-12	1 .
after al", c	ğ.	3 Widowed 4 Divorced If Yes, Give Year or Dates: 12-7-41-5-15-45 1 Yes 2 No specify:		Specify Frich	an HMERICAN
136 hin 72 hours after e than "natural", c	ᄝ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/I	ndustry
36 n 72 nan "	Set	Elementary/Secondary (0-12) College (1-4 or 5+) 12 4h NERChan SeamA	(STAILA	
within giene her that	Completed		ne (First, Middle, M		<u> </u>
215-0C e filed wit tal Hygien ked other nt, the M		(1)a/ER (V)/I/Ams Ilene	/ /		
ID 21215-0036 should be filed within 7 and Mental Hygiene 77 is marked other that matic event, the Medicy	o Be	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			, Zip Code) 21228
AD 21 2 should h and Me 27 is ma		Heled C. Williams 303 Maiden Choice	e lane-c	atonsvide 1	Aci lond
e, M 1 and 2 Health Tream	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 72 hours after partment of Health and Mental Hygene portant: If item 27 is marked other than "natural", jury or other traumatic event, the Medical Examiner		1 Burial 2 Cremation 3 Removal from State crematory or other place)	mber 20, 2006	Calmacium	6 Marchant
드 ~ 운 등 등	-	4 Donation 5 Other Specify: 24 Signature of Funeral Service Licensee 22. Name and Address of Facility	2000	CHITOYISUM	Cer, MITTE GITTES
Balti permit. Departn Import injury	1	Signature of Funeral Service Licensee 22. Name and Address of Facility Ancy m. William 3405 W. Familia.	ce rung	sitimore 1	macilia 21229
Physician	-	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Contact Gunshot Wound of Head			Death
r ≒xaminer	- 1	or condition resulting in death) Due to (or as a consequence of):			
\smile	.	Sequentially list conditions, b.			
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
٦ ـ	am	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
and and - transit		d			
O, be exe	ledical	UNPENDED			
	Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregr	ancy	23d. Date of deliver Month	y Day Year
Sox 6876(leath certificate e attending phy- for use as the b	iai	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	laricy	WOTH	Suy Tour
Box 6876 e death certificat the attending phy	hysician/M	1 Yes 2 No 9 Unknown g Unknown			
that the ned by the detached	0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
P.O.	ğ		1 Yes	2 V No 3 Pro	pably 4 Unknown
ords, * requir s been s should	Completed		24a. Was a		utopsy findings available completion of cause of
COT e law e has l	립		perform	med? death?	
Rec: The liftcate h		25. Was case referred to medical 26. Place of Death (Chec		Z NO I	2 110
Vital ysician: his certifi director,	a	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other		Residence 6 🗸 Othe	r. Scene
Division of Vital Records, rate dearn and or Attending Physician: The law requires a state death After this certificate has been silled in by the funeral director, page 2 should be in by the funeral director, page 2 should	유	Tes 2 No		now injury occurred	
onding th r: Af	ö	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? FOUND: FOUND: FOUND: 1 Yes 2 ✓ No	Subject shot	himself	
iSiC Atte er dea rector	ical	2 Accident Investigation Dec 15, 2006 1540 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Div tal or rs afte	Certification:	3 ✓ Suicide 6 Could not be determined 4 Homicide 6 Could not be determined (Specify) Other (specify) Outside of apartment	or Town, St 303 Maiden C	tate) hoice Lane Apt. 323,	Catonsville, MD
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Cortificing Physician: To the best of my knowledge, death occurred at the time, date and place, at	nd due to the caus	e(s) and manner as sta	led
Thin 2	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	d at the time, date a	and place, and due to the	ne cause(s)
To To To	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
		My M, M. O.C.M.E.		December 16, 2	006
		30. Name and address of person who completed cause of death (Item 23a)	_	L	
Vo.		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
s	tate	31. Date filed (Month Cay, Year) 2006 32 Registrar's Signature		_	
Regis		DEC 1 8 2006 Reserve 25 April 2006			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM 20c. per H . (362, 12/18/06 WS
State of Maryland 7 Department of Health and Mental Hygier () () () 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 4th 2006 Winegan lane December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMBATAN
5. Social Security Number 6. Sex 705P, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2 12 F 217-/6-/337 Usual Residence of Decedent Yrs. M.D 10b. County 10a. State. 10c. City, Town or Location 10d. Inside City Limits MI 1- Yes 2 □ No BA 170 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 21213 14 MAON DR 4.5 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 XNo Specify 3 Widowed 4 □ Divorced Specify: BIACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Th omestic Worker Clean NOAZ 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 6-RIF-10 lorence UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -RANK BA110.10.00.01213 WinegAn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BETTS FineRAL H 57 BA177 ·mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Ogset and Death Char Due to (or as a consequence of): lle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2) No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient examiner? 1 Yes 2000 Other: 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death
1 X Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Physician /Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Division of Vital Records, P.O. Box 68760, attending physicien page 2 should be detached filled in by the funeral director, After this death. Director: within 24 hours

Physician

/Medical

Examiner

Director

Completed by Funeral

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Physician/Medical

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Certification: To

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Items 23a or 28a-f show

permit. Page Department of Important: If eny injury or once.

Baltimore, Maryland 21215-0036

fraumatic event, the Medical Examiner must be notified at

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type) Print) Kalen 32. Registrar's Signature,

2006

29c. License number

mole,

29d. Date signed (Month, Day, Year)
DIDPON MINEL 13 12006

			1 - State Amend item#14, per	ate of Marylan	d/Depa Cei	artment rtificate	t of H	ealth a Death	and Me		giene		40230	
	Physici	an	Decedent's Name (First, Middle, Last)		-					2. Date of De		Year Year	3. Time of Death	
	/Media	cal	MONIQUE 4a. Facility Name (If not institution, give street	WILLIAM	S	45 035	T	1		DEC.		2006 ^{Year}	7:15PM	
1	Examir	ner	2419 W. LEXINTON					Location o			1	: County of Death N/A		
	Funeral Director		5. Social Security Number 6. Sex 169-625218 1 □ M :	7. Age (In yrs. 2		If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Oa JULY	y, Year)	Cou		
	ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits	
	e Man	ctor	MD. N/A		BALTI	MORE							1 X Yes 2 □ No	
	th with th	Funeral Director	10e. Street and Number $1231\ N.\ POTOMA$	C ST.		10f. Zip	Code 212	213			10g. Ci	tizen of What Cou USA	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiane. Important: If item 27 is marked other then "naturel", or iteme 23e or 28e-f ehow entry figury or other treumatic event, its Medical Examinant to intiffice at ance.	by Funer	1 Never Married 2 Married 1	as Decedent Ever in U. med Forces? □Yes 2√ΩNo Yes, Give X ear or Dates:		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig , Mexican Specify:	jin? (Spec , Puerto R	fy Yes or No ican, etc.)		14. Race - Ameri Black, White, Specify: IIC A	etc.	
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Baltimore,	permit. Depertrimportri		21 Sunature of Funeral Service Licensee	eruses	. 22	CALV	d Address	of Facility S. SC	RUG	GS FUI	NER	AL HOME	21213	
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	To the Hospital or Attandi within 24 hours effer death. To the Funerel Director: A \completely filled in by the to	Medicai		To the best of my known the basis of examinated manner stated.	wledge, death ion and/or inv	occurred a restigation,	it the time in my opi	nion, deat	t place, an h occurred	d due to the d at the time, d	date and) and manner as s d place, and due to	tated. o the cause(s)	
	With	2	29b. Signalure and title of certifier	n PHYSI	CIAN	29c.	License P5	number 359	0			te signed (Month,	Day, Year)	
	1		30 Name and a set set of person who completed by MD	ed cause of death (Item	23a) (Type, I		24	٦	BR	ADWA	MO	21205		
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 8 2006	32. Rigistrar's Signat	ure	ale								

i or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Medical

Year) 16 2006

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6701 32. Registrar's Signature

and manner stated

		1	For State Registrar	State of Marylan				ealth ar D <i>eath</i>	nd Mental H	ygiene Reg. No.	006	40232
	Physici	an	1. Decedent's Name (First, Middle, Last		J	WR	0	レエ	2. Date of I Month	Day	Year	3. Time of Death 6:50 PM
	/Medic Examin		A L F.R. 4a. Facility Name (If not institution, give				Town, or	Location of I			07 2006 ounty of Death	6.30)
	Funeral Director		Bon Secours Hosp: 5. Social Security Number 216-36-0418			If Unde Months	r 1 Year	If Under 24 Hours	Hrs. 8. Date of E	Birth Bay, Year) 23, 193	9. Birthp	place (State or Foreign ntry) unk
Ь	D		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	the Mar 28a-f et	ector	MD 10e. Street and Number	I	Baltimo		o Code			10a Citize	n of What Cour	1√ Yes 2 No
	with	ä	1937 Herbert Stre	. o. t		101. 21		217		109. 01.120	USA	my:
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-f ehow other traumatic event, the Medical Exprinter must be invitted at	by Funeral Director		12. Was Decedent Ever in U	unk	Was Dece If Yes, spe 1 Yes	dent of Hi cify Cuba		n? (Specify Yes or Puerto Rican, etc.)		Race - Americ Black, White,	etc.
21215-0036	within 72 houene. Then "nature The Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) unk u	cation (e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wi DO NOT u	ork done d	lurina most o	unk f working	16b. Kind	of Business/Ind	dustry unk
Maryland 2	4.2 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, the He	To Be Co	17. Father's Name (First, Middle, Last)	шк			unk	18. Mother's	Name (First, Midd	lle, Maiden Su	итате)	unk
lary	and N		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Mailie	ng Addres	s (Street a	and Number	or Rural Route Nun	ber, City or T	own, State, Zip	Code)
Baltimore, M	Page ent o nt: if ry or	8	Bon Secours Hosp: 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ If 4 □ Donation 5 ▼Other (Specify,	Removal from State	2000 Place of Disposemetery, cred	osition (Na	me of		Street Ba Date		e,MD tion - City or To	
Balti	Departm Departm imports any inju		21. Signatur Service Licens	Wade irector	r S	2. Name a tate altim	Anat Anat	omy Bo MD 2	ard 655 W 1201	. Balt	imore S	Street
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	uires that n signed b ild be deta		Part II. Other significant conditions co	•	ulting in the u	ndertying	cause give	en in Part I.		d tobacco use		he cause of death?
Division of Vital Records,		Completed by	PERMEN	ANT PALE	MAK	ER			ре	as an 2 topsy rformed? 2 No	24b. Were auto prior to co death? 1 ☐ Yes	ppsy findings available impletion of cause of
N S	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			Othe		f Death (Check on)			
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 (Month, Day Year)	28b. Time o Injury		28c. Injury Work			e how injury o		у)
Divis	tal or Atters after designation of Directors ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At his building, etc. (Specifical Control of the Control o	ome, farm, str	reet, factor	y, office			(Street and Nown, State)	Vumber or Rura	al Route Number,
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	To the within To the comp	W.	29b. Signature and title of certifier	Stallatis	MD.		D >			1	signed (Month,	
			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type,	Print)	130	N 52	ECONP3	HUSP),3 CM	07 2006
	√	ate	SUDMIR: D 31. Date filed (Montp. Day, Year) 20	PATE 2, M	D . :	200	ow	1342	TO. ST	13427	O MI	7.21223
	Regist		DEG T 9 50	100 R2 843 1	C. C. S. S. S. S.	Co. Co.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** SHIRLEY ARNOLD 10:03 PM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 22, 1933 Baltimore, MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2□F Hours 73 Yrs. 216-32-3604 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Heelin and Merlait Hygione. The firem 21 is marked other than "natural, or terms 23e or 28e-f show other traumatic event, he Medical Examinar must be notified at MD Carroll Westminster 1 ☐ Yes 2 ₩ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 St. Hales Ct 21158 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify à Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Milford Mill Church Efementary/Secondary (0-12) Colfege (1-4or 5+) Preschool Teacher Child Development Ctr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Russell J. Loock Mary Madalyn Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heelth and Importent: If Item 27 is n any injury or other traun once. Paul C. Arnold, Jr. - Son 930 Winters Church Rd., Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20a. Method of Disposition 20c. Location - City or Town, State ty⊋Burial 2 ☐ Cremation 3 ☐ Removal from State 12/04/2006 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 21157 412 Washington Rd. Pritts Funeral Home & Chapel, P.A. Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MLTERED MENTAL **Physician** STATUS /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit INFECTION LRINARY TRACT that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DEMENTIA 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 🗓 No 2 No ours after death.

neraf Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 🖾 Naturaf 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the

with

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or Attending

The law requires thet the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) MOV 3 0 2006

KANU - 3233

29b. Signature and title of certifier

Meny

SUPERIOR LN 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, B 21. BOWIE , MD 20715.

29c. License number

D0058580

29d. Date signed (Month, Day, Year)

2006

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, ettending for use as s certificate has b Director: within 24 hours after d To the Funeral Direct completely filled in by

Physician

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Itam 27 is marked other than "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed with Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other ther any Injury or other traumattic event, it at MDGB.

Physician

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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Prostate Hyperk	contributing to death but not res		ause given in Part I.	23e. Did tobacco	24b. Were a prior to death?	o the cause of death? Probably 4 Unknown utopsy findings available completion of cause of s 2 No
25. Was case ref medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	15D/Outration of Do	Other	ath Check only one)		
1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	8c. Injury at Work? 1 Yes 2 No	Home 5 Residence 28d. Describe how in	6 ☐Other (Speury occurred	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, factory	, office	28f. Location (Street a City or Town, Sta	and Number or R te)	Bural Route Number,
29a. Certifier 1 Certifying	Physician: To the best of my kn aminer. On the basis of examin- and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and plac , in my opinion, death occ	e, and due to the cause(urred at the time, date at	s) and manner a nd place, and du	s stated. e to the cause(s)

29c. License number

1200060756

223 w Main St. Elbon, MD

29d. Date signed (Month, Day, Year)

12/1/2006

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		-	1 - For State Registrar	State of Maryla			t of Health and Ne of Death	R	leg. No.	40235			
	Physici /Medic		Decedent's Name (First, Middle, L Bernard Andrejk	covics				2. Date of Dear	30 2006	3. Time of Death 730 A M			
) 	Examin	er	4a. Facility Name (If not institution, g Laurel Regio 5. Social Security Number 6.	nal Hospital	rs. last birthday)	4b. City,	Town, or Location of Death Laure 1 Year If Under 24 Hrs.	8. Date of Birth		George's			
	Funeral Director		103 05 3151 Usual Residence of Decedent	15km 2□F 86	Yrs.	Months		(Month, Day 11/15/1	920 New	nplace (State or Foreign unity) York			
	Maryland	tor	10a. State 10b. County MD Howard		City, Town or Lo		Y			10d. Inside City Limits 1 ☐ Yes 2 🕍 No			
	h with the 23a or 284 at be not	Funeral Director	10e. Street and Number 3822 Plum Meadow	Dr.		10f. Zip	Code 21042	1	untry?				
920	within 72 hours after deeth with the Maryland ene. than "natural", or Itams 23e or 28e-f ehow has Masical Examinar must be notilied at	ē	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Styles 2 □ No19 If Yes, Give Year or Dates: 194	42-	Was Dece If Yes, spe	dent of Hispanic Origin? (Sport of Hispanic Origin? (Sport of Cuban, Mexican, Puerto 2 \text{No Specify:}	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	e, etc.			
Maryland 21215-0036	a within 72 ho jene. r than "natur ine Madical	Be Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12	Education grade completed) College (1-4or 5+)	(Give	kind of wo	al Occupation rk done during most of work se retired) Vice Preside	ent	Industry Facturing				
/land	unid be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, La. John Stephen And				Mary Mo	lnar	Maiden Sumame)				
	and 2 sho leelth and i m 27 is mu		19a. Informant's Name/Relationship Diane Demes/daug	ghter	3822	Plum	Meadow Dr.	Ellicot	r, City or Town, State, 2 t City, MD 20c. Location - City or	21042			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is merked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Examinat man be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice)	Commetery, crematory or other place) St. Charles Cemetery 12/5/2006 Farmingdale, NY									
· A	Physician /Medical Examiner	lner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading or immediate cause. Enter Underlying	//	SCLER sequence of):	er the moo	-01		rest, LAR DISE	Approximate Interval Between Onset and Death			
8760,	cate be executed oblysicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):								
.O. Box 68	res that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	⊒Ectopic p ⊒ Other <i>(s</i> j			23d. Date of del Month	ivery Day Year			
rds, P	The law requires that the ste has been signed by the bage 2 should be detache		Part II Other significant conditions	a contributing to death but not	resulting in the u	inderlying o	ause given in Part I.		obacco use contribute to es 2 No 3 Pr				
Vital Records,		Completed						24a. Was a autops perfor 1 □ Yes	an 24b. Were au prior to death?	topsy findings available completion of cause of			
of Vita	ding Physician: Th th. After this certificete funeral director, pag	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year	ER/Outpaties 28b. Time o		04		ne) dence 6 □Other (Speciow injury occurred	cify)			
Division of	or Attending after death. Director: After in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could not 4 Homicide determine	tion	At home, farm, st	М	1 Yes 2 No	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ural Route Number,			
	To the Hospital or Attenwithin 24 hours efter deatl To the Funeral Director:	edical Ce		Physician: To the best of my saminer: On the basis of examand manner stated.									
	To the within To the Comple	Me	29b. Signature and title of certifier	n Lallie	2440	29	c. License number	2	29d. Date signed (Mont	h, Day, Year)			
90	· ~		30. Name and address of person when TASNEEM	AKHANI,	7220	Print)	CK HEIGHT	3 ANE	BARRA	m1 21200			
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			For State Registrar	State of Maryland		rtment of He			ene2 () () () . No.	40236			
			Decedent's Name (First, Middle, Last)					. 140.	3. Time of Death				
	Physicia	an		lrews				2. Date of Death Month	Day Year 25, 200				
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	Novellibei	4c. County of De				
	Examin	er				,			,				
	Francis		Montgomery Genera 5. Social Security Number 6. Sec		st birthday)	If Under 1 Year	1ey If Under 24 Hrs.	8. Date of Birth	Montgo	mery irthplace (State or Foreign			
	Funeral Director		1□]M 2√□F	Yrs.	Months Days	Hours Min.	(Month, Day, Y	Country)				
			300-14-3850 Usual Residence of Decedent	82				OCC. 20	, 1924 C	/IIIO			
	yland		10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits			
	Mar	to	Maryland Montgomer	v Sil	ver S	nrina				1 ☐ Yes 24 ☐ No			
	n the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What (Country?			
	h wit	0	14400 Homecrest F	Road, Apt. 100		20906	;		USA				
	deet	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		as Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race - An				
0	after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Yes, specify Cubar		Hican, etc.)	Black, Wh				
3	rai',	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	□Yes 2√27√10	Specify:		Specify: Wh	ite			
5	72 h	Completed	15. Decedent's Edu (Specify only highest grade			ent's Usual Occupa		16	b. Kind of Busines	s/Industry			
7	thin and	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired)	army most or work	9					
7	Adam the the	So		4	Di	etician		Foo	od Servic	e			
2	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "netural; or iteme 23s or 28s-f ehow event, the Medical Examiter mant be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)				
ğ	should to	၉	John D. Andrews				Kathe	rine Ondr	us				
0	and and in man		19a. Informant's Name/Relationship (Ty					al Route Number, C	City or Town, State	Zip Code)			
2	and eelth n 27		Mardelle Channon/	Personal Rep	178	Ol Georgi	a Avenu	e, Olney,	MD 2083	2			
5	Tite /	,	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R	con	ce of Dispos netery, crem	ition (Name of atory or other place	2)		c. Location - City of	r Town, State			
	Pages nent of I ant: if its ury or o		4 Donation 5 Other (Specify)		of Heave	en Cemetery		mber 1, 06 Si	lver Spr	ing, Maryland			
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 ie marked other than "netural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Experies must be pulified at ones.		21. Signature of Funeral Service License	90	F ²²	Manage Ageres	collins	Funeral H	lome Inc.	g, MD 20901			
			23a. Part1. Enter the disease, or compli	nations that as und the death					-				
			shock, or neartfailure. List only or	e cause on each line.	Do not ente	i the mode of dying	, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death			
	Priysician		Immediate Cause (Final disease or condition resulting in death)	Myocardial In	farct	ion				one week			
	/Medical Examiner		resulting in coatry	Due to (or as a conseque	nce of):								
			Sequentially list conditions, if any, leading to immediate	Aortic Stenos		ritical				approx. 1			
	sit 9d	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce or):					year			
	and tran	кап	that initiated events resulting in death) Last	Due to (or as a conseque						one week			
Š	cien cien	Ë			,								
5	cate ohysi the t	dicai		Respiratory E	allur	B)				one week			
2	ding p	Me	IF FEMALE:	a_ #.155									
Š	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1□Live birth 2□Fetal d	eath 3 1	Ectopic pregnancy			23d. Date of d Month	elivery Day Year			
5	the a	sic	1 Yes 2 No	4□Pregnant at time of dea 9□Unknown	th 5∐	Other (specify)	1						
	d by letac	F.	Part II. Other significant conditions cor	Asib tion to death but and an all	:- db	4-4-1		and Distance		to the cause of death?			
<u>r</u>	res ti	þ	Coronary Artery Di		-								
5	neen s	ted	TOTAL TIPE OF BE	bease, hypoten	51011,	CHIONIC	ODSTIUCE	IVE I THE	2 NO 3 1	Probably 4 X Unknown			
ב ט	law as b	ple	Pulmonary Disease					24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of			
5	The ate h page	Completed						performe 1 ☐ Yes 2 🔀	d? death?	s 2 No			
2	itan: artific ctor,	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)					
-	hysic nis ce i dire	2	1 ☐ Yes 21 No	lospital: 1 Inpatient 2 I EF	NOutpatient	3□ DOA Othe	r: 4 ☐ Nursing Ho	me 5 ☐ Residenc	e 6 Other (Sp	ecify)			
) =	ng Pl fter ti nera		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred				
2	ath.	atic	2 Accident investigation				es 2 □No						
<u>~</u>	er de recte	ij.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,			
2	rs aft	Certification:		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				,,					
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Phys	sician: To the best of my knowledge. On the basis of examination	edge, death	occurred at the time	e, date and place,	and due to the caus	se(s) and manner a	as stated.			
	in 24 he F he F plete	ledical	one)	and manner stated.	ri aniuvor invi	sanganon, m my op	miori, deatri occur	ou at the time, date	anu piace, and di	ie io ine cause(s)			
	To t	Σ	29b. Signature and tula of contifier	-		29c. License			. Date signed (Mor				
			18	To the same		63	192		November	26, 2006			
	5		30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Type, F	Print)							
			Shawn Tweedt, D.O	. 18101 Prince	Phil:	ip Drive,	Olney,	Maryland	20832				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	е	9							
	Registr	ar	DEC - 1 2	2006 Comment of the contract o	OF A	and o							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Akselrod November 27, 2006 4:05 A_M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Casey House Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2√ F 220-33-7276 4/26/1919 Ukraine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Gaithersburg 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17060 King James Way #405 20877 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White **X**☐Widowed 4 ☐ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miriam "Unknown" Boruch Akselrod 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14168 Saddle River Drive Gaithersburg MD 20878 Michael Snyderman - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Grdns 11/29/06 Olney, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f show ner must be notified at

Completed by Funeral Director

Be (

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Cynthia M. Williams

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. pegistrar's Signature

within 2.

thin 24 hours after death.

the Funeral Director; A
pmpletely filled in by the fu

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

2

	immediate Cause (Final disease or condition resulting in death)	a. Metastatic Cancer of Unknown Pri	mary	Onset and Death
	resulting in death)	Due to (or as a consequence of):		
	Sequentially list conditions, if any leadin, to immunish cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for as a consequence of:		
culcal Eva	resulting in death) Last	Due to (or as a consequence of):		
I) SICIEITING	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of de Month	livery Day Year
	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
or Indian			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes	utopsy findings available completion of cause of
2	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
	1 ☐ Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Spe	cify) Hospice
	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	nospice
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,
	29a. Certifier 1 Certifying Phy cone) 1 Medical Exam	rsician: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause(s) and manner as red at the time, date and place, and due	s stated. e to the cause(s)

29d. Date signed (Month, Day, Year)

2006

DHMH 17 Rev 1/2001

State Registrar

40058032

6001 Muncaster Mill Road Rockville MD 20855

40238 State of Maryland / Department of Health and Mental Hygiene?

Discontinuo
Physician
/Medical
Examiner

Director

Funeral

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depentment of Heatth and Mental Hygiene. Important: if item 27 is marked other then "neturat," or iteme 23a or 28e-f show eny folgry or other traumatic event, it a Medical Examinar must be notified at 90nes.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 - State Registrar		C	ertificate of	Death		Reg. No.					
1. Decedent's Name (First, Middle, L	ast)				2. Date of De	te of Death 3. Time of Death					
Simeon El	lsworth	Brown			Novembe	er 29	2006	5:00A	М		
4a. Facility Name (If not institution, gr			4b. City, Town, o	r Location of			ity of Death	7.00/1			
Lorien Nursing &				ytown			arroll				
5. Social Security Number 6. 213-18-8372		ge (In yrs. last birthd 94 Yrs	Months Days		Min. 8. Date of Bir (Month, Date of Aug • 2	th Year) 912	9. Birthp Coun Mary	lace (State or F itry) / land	-oreigi		
Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town o					1	0d. Inside City			
Maryland Carr	-o11		Unic	n Bric	lge	10g. Citizen o	f What Coun	1 🔀 Yes 2	□ No		
301 E. Locus	st St.		101. 2p 0000	21791			U.S.A	•			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tes 2 If If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 → No		n? (Specify Yes or No Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	16b. Kind of										
11 millroom worker cemen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)											
William Thomas					uth Minerv						
19a. Informant's Name/Relationship		F	ailing Address (Street								
Marva M. Redd/da 20a. Method of Disposition	augnter	20b. Place of Di	White Wir sposition (Name of		Date Date	20c. Location					
1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			crematory or other places Cemetery	·	2/4/2006	nr. Ne	w Wind	dsor, M	D		
21. Signature of Funeral Service Lice	1 / DE	Per			Hartzler F			701			
23a. Part 1. Enter the disease, or conshock, or heart failure. List only	mplications that carse	d the death. Do not		25.5	Union B ardiac or respiratory a		rio Zi,	Approximate Interval Between	100		
Immediate Cause (Final disease or condition resulting in death)	a. Cor	nest	ve de	unt 1	Fulne			Onset and Dea			
Sequentially list conditions,	b. Due to (or as	a confequence of):	opathy				14				
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. 14p7	a consequence of):	' 0				-	257	_		
	d. and	work						944	,		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	,			Pate of delive	ry Day Yea	ar		
Part II. Other significant conditions	contributing to death t	out not resulting in th	e underlying cause giv	en in Part I.	23e. Did t		ntribute to th	e cause of deal			
					24a. Was	an 24b	. Were autor	osy findings ava	ailable		
25. Was case referred to medical	1				1 ☐ Yes	2 No		2 No			
examiner?	Hospital:	ent 2 ☐ ER/Outpa	tiont 3 DOA Oth	0.5	f Death (Check only o						
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpati 28a. Date of Inju (Month, Da	ury 28b. Tim	e of 28c. Injur	48014013	28d. Describe			7			
3 Suicide 6 Could not 4 Homicide determine	d 286. Place of in	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (City or To	Street and Nun vn, State)	nber or Rura	Route Number	Γ,		
29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best aminer: On the basis of and manner st	of examination and/o	eath occurred at the tir r investigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and n date and place	nanner as sta e, and due to	ated. the cause(s)			
29b. Signature and title of certifier	Mill	It mr	29c. Licens	e number	Y V 2	29d. Date sign	ed (Month, L	Day, Year)			
39. Hame and address of person who	o completed cause of	death (Item 23a) (Ty	pe, Print) RA 4	note.	cha M	0 2	UFT	V 10			
31. Date filed (Month, Day, Year) DEC 0 4		rar's Signature	, in the	11 200 16	ייי ליאנו	V ON	17/				
	2006										

State

Registrar

MJY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item 11 per wife 3/21/08 dk Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FRANKLIN 12 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RegioNOS 3 AUSBUM HICOMICO MIdICA If Under 1 Year | If Under 24 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) NDV 03 19 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 🕱 M 2 □ F 220 329488 VIRGINIA 1936 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director NEW CHURCH ACCOMACK VIRGINIA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23415 USA 32967 VERNON Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No Il Yes, Give 3 07 13 1953 Year or Dates: \$607 30 1915 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Specify: WHITE Specify. þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. COAST GUARD permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manan injury or other traumatic event the Manan Elementary/Secondary (0-12) College (1-4or 5+) BM 1 CLASS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEEBE GOLDIE BOWDEN DANIEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SALISBURY, MD. 21804 119 AVE HOLLAND CYNTHIA RENSE BOWDEN CORBIN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) JOHN W. TAYLOR CEMETERY DEC. US 2006 TEMPERANCEVILLE VIRGINIA 22. Name and Address of Facility FOX & HOLSTON FUNGRAL HOME 5049 CHICKEN CITY ROAD 21. Signature of Funeral Service Licensee CHINCOTEAGUE, VIRGINIA 23336 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final onen Apy **Physician** 244 eurs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cerdiony Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1□ Yes 2 No certificate 2 □ No 1 ☐Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide in 24 hours. the Funeral Dire Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen CARROLL Salisbury Md. 2180 MEIM MD

Registrar

State

31. Date filed (Month, Day, Year)

05

2006

DHMH 17 Rev 1/2001

32. Registrar's Signature

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			State Registrar			Ce	rtificate	e of	Death			g. No.	.006	4024	1
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			Greater Baltimore					son	If Under 24 I	Hrs o	Date of Righ		1timor		-1
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			Usual Residence of Decedent		0-7										
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	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ahow the Massical Examiner massice mutified	Be Completed by Funeral Director	10e. Street and Number				10f. Zip				10	_	en of What Co	ountry?	
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-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy	sicien: To th	e best of	my knowledge, dea	th occurred	at the tir	me, date and p	olace, and	I due to the ca	use(s)	and manner a	s stated.	
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ME.	Physicia	an	Decedent's Name (First, Middle, Last) Florence Mary I	Bazan			Date of Death Month	^{Day} 29, 2006	3. Time of Death
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ye.			2005 Henry Hutchins Roa	-	Prince F			Calvert	(0)
**************************************	Funeral Director		5. Social Security Number 131−38−6663 Usual Residence of Decedent 6. Sex 1 □ M 2 □ F	7. Age (In yrs. last birthday) 91 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Ye Peb 27 19	ar) Coun	
	yland now at		10a. State 10b. County	10c. City, Town or Lo	cation			10	0d. Inside City Limits
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	Armed	S 2 No Give	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐ No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - America Black, White, e Specify: whi	etc.
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Maryland 21215-0036	uld be file Mental Hy rked othe tic event	To Be (17. Father's Name (First, Middle, Last) Thomas D. Bolton			18. Mother's Name (Florence		y Shepher	đ
Mary	and 2 sholl alth and N 27 is mast ranma		19a. Informant's Name/Relationship (Type. Print) Dorothy E Bazan-Greene-	daughter 349 H	olmes St.		Route Number, Ci Massachu	ty or Town, State, Zip 1 setts 023	Code) 38
Baltimore,	Pages 1 ament of He ant: If Item jury or othe	13	20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 ★ emoval from 4 □ Donation 5 □ Other (Specify)	Memory's	Garden Ce	ellecery	16	Location - City or To	
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	^		30. Name and address of person who completed ca	auge of death (Item 23a) (Type.		16823	- 1	2006	
-	10		Robert J. Schlager, MD	110 Hospital F		te 111, Pr	ince Fre	derick, MD	20678
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			For State Registrar	State of	Marylan		artment of I					006	402	243
			Decedent's Name (First, Middle	e, Last)				Doda		2. Date of Deat	ng. No.		3. Time o	f Death
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	/Medic Examin		4a. Facility Name (If not institution			DOWCII	4b. City, Town,	or Location of		DCCCIIDC.		unty of Death		
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	Funeral		5. Social Security Number		Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birth	place (State	or Foreign
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			Usual Residence of Decedent							Juli 17	, ,,,,,		julia	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside C	ity Limits
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	or 28	Director	10e. Street and Number				10f. Zip Code			11	0g. Citizer	of What Cou	intry?	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. The Interpretation of Health and Mental Interpretation of the recognition of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of the Interpretation of Interpretat	Be		eshield	Bowen					(First, Middle, Mane		_		
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Вох	eath certifi attending I for use as	ciar	in the past 12 months?		h 2 ☐ Fetal nt at time of de		Ectopic pregnanc Other (specify) _	у			230.	Month	•	Year
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o	th.: Afte	亨	1 Matural 5 Pendin 2 Accident investi	9	Day Year)	Injury		rk? ∣Yes 2.∐1	No					
/isi	Attending Physician: r death. sctor: After this certificator, the funeral director.	fica	3 ☐ Suicide 6 ☐ Could	in 289. Place of	f Injury - At ho	me, farm, stre	eet, factory, office		2	8f. Location (Str	eet and N	umber or Run	al Route Num	ber,
ă	in Sign	Certification;	4 Homicide	building	, etc. (Specify	<i>(</i>)				City or Town	, State)			
	To the Hoepital or Attending Physician: within 24 hours eiter death within 24 hours eiter death atto the Funeral Director. To the Funeral Director After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifyin	g Physician: To the b	est of my kno	wledge, death	occurred at the ti	me, date and	d place, a	nd due to the ca	use(s) and	d manner as s	stated.	
	ne Ho	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examinat r stated.	tion and/or inv	estigation, in my o	ppinion, deat	th occurre	d at the time, da	ite and pla	ce, and due t	o the cause(s	}
	withir To th comp	×	29b. Signature and title of certifie	· · ·	D.		29c. Licens	se number		29	d. Date si	gned (Month,	Day, Year)	
			ATTYU	Cender	Phys	eic.		19	42	7 1	2 -	4 -	200	6,
A			30. Name and address of person	who completed cause	of death cerr	23a) (Type,	Print)	- > ©) .		1		10 c	- ~- ~
3	ተነ		ANWAR MUN	SMI. MD.	110	HOSP	ITAL &	ZD . [rene	e tre	don	clc n	102	0676
	Sta		31. Date filed (Month, Day Year)	32. Reg	jistra s Signa	ture	Sparke							
	Registr	ar	DEC	4 ZUUb	Placer	15	Goale	V						

			1- State of Maryland / Dep	partment of Health and Nertificate of Death		ene 2006 40244							
	Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death							
	/Medio Examir		Robert Glenn Black 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	December	10, 2006 1315 P ^M 4c. County of Death							
			2 Norman Allen Street	E1kton		Cecil							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 238-30-5028 1 M 2 □ F 81 Yrs.		8. Date of Birth	Birtholace (State or Foreign							
ļ.	Director		238-30-5028		AUG 7, 1	925 North Carolina							
	yland how		10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits							
	Ba-f el	Director	Maryland Cecil Elkton			1 ☐ Yes 2 ☑ No							
	with th	Dire	10e. Street and Number	10g	g. Citizen of What Country?								
	ne 23	eral	2 Norman Allen Street 11. Marital Status 12. Was Decedent Ever in U.S. 13	21921 Was Decedent of Hispanic Origin? (Sp	poofu Voc or No.	United States 14. Race - American Indian,							
٥	after o	by Funeral	1 Never Married 2 Married 1 Myes 2 Norld	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.							
5	ural', c	d by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: War II	1 ☐ Yes 2 📉 No Specify:		Specify: White							
Z 1 Z 1 3-0036	"nate	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king 16	b. Kind of Business/Industry							
7	iene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	pervisor		Automobile Manufacturing							
land	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "natural", or itame 23a or 28a-f ehow event, I're Medical Exertifier must be notified at	BeC	17. Father's Name (First, Middle, Last)	-	e (First, Middle, Ma								
N S	should be and Mental marked o	ToE	Ira Black	Mattie	Woods								
Mar	12 sh and rie m			ing Address (Street and Number or Run									
a) -	ges 1 and 2 should tof Health and Mer if Item 27 ie marke or other traumatic		Irene Black/Wife 2 No 20a. Method of Disposition 20b. Place of Disp	rman Allen Street,		Mary 1 and 21921 c. Location - City or Town, State							
ашто	permit. Pages Depertment of h Important: if its eny injury or of		Actual E Boronation o Brighton State	matory or other place) Decer	mber								
	mit. F pertm sortar / injur		HIRCOI	Cemetery 14, 2	2006 <u>E</u>	lkton, Maryland							
Ď	Depermine the policy in po		Christen Hicko Cummen 1	icks Home for Fune 03 W. Stockton Str	rals, P.A eet. Elkt	on, Maryland 21921							
	Physician /Medical Examiner	ıer	Approximate the first disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
,00/00	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	ledical Examiner	d										
.O. DOX	Physician: The law requires that the death certific this certificate has been signed by the attending p al director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year								
'n 'n	es tha gned I be det		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?							
	requir	sted	Congestive Heart Factore		1 🗆 Yes	2 ☐No 3 ☐ Probably 4 ☐Unknown							
ם שב	: The law cete has t	Completed by	Peripheral Vascular disease		24a. Was an autopsy performed								
\	siciar certif irector) Be	25. Was case referred to medical examiner? 1 Yes 2 No	100	h (Check only one)								
5	g Phy er this eral d	lon: To	27. Manner of Death 28a. Date of Injury 28b. Time of	A Nursing Ho	me 5 Residence 28d. Describe how	e 6 Other (Specify)							
5	arth. pr: Aft	atio	1 ⊟natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		. ,							
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	Hosp 24 hou Fune stely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h contined at the time, date and plane, westigation, in my opinion, death occurr	and due to the caus ed at the time, date	and place, and due to the cause(s)							
	To the Mithin To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)							
	a l		Mober al Markeline MD	D0053675		111106							
1	3+1		30. Name and address of person who completed cause of death (Item 23a) (Type Note: A. Monte (Cone, MD) 1/1/ 31. Date filed (Month, Day Year) 32. Registrar's Signature	Print) W. HyLSt. Suit	e 214, E	1kton MO 21921							
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A. N.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Wright Blackmon 5:12A M 2-2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Oldtown 21201 Wagner Cutoff Road, SE Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Months | Days | Hours | Min. | Min. | Oct 24, 1937 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 € M 2 □ F NC try) 69 567-54-9618 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "naturel", or items 23a or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Allegany MD Oldtown 1 ☐ Yes ¾☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 Wagner Cutoff Road S.E. 21555 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 X Yes 2 □ No ff Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced Year or Dates: Korean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) engineer maint, supervisor Thomas B Finan injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Buck Blackmon** Ruby Blackmon ၉ 19a. Informant's Name/Relationship (Type, Print) Agnes Blackmon 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 21201 Wagner Cutoff Rd Oldtown MD 21555 permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is m any injury or other traum wife 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Buriaf 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 12/13/2006 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nam Scarbellis Punellal Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Finaf **Physician** (0 disease or condition resulting in death) 101 clean /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. ff yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2 No 2 □ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medicaf 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how infury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D36766 December 12, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) M.D. 924 Seton Drive Cumberland MD 21502 Vikramaditya Poonai M.D. 31. Date filed (More Pay Year) 2006 State Registrar

06-09363 - -Brenda E. Barlow

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Certific	eate of Death	Reg	No. 0005 1001				
Physiciai Medical Examin	n/	1. Decedent's Name (First, Middle,Last) Brenda Elizabe	eth Barlow	2. Date of Death Annual Street					
		4a. Facility Name (if not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington					
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last bit) 175-40-4316 1 M 2 XF 59	tthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		MM/DD/YYYY) 9 Birthplace (State or Foreign Country) PA				
2 hours after death with "natural", or items 23.	l Director	Elementary/Secondary (0-12) College (1-4 or 5+)	Hagerstown 10f. Zip Code 21740 13. Was Decedent of Hispanic Origin? (Sign Yes, specify Cuban, Mexican, Puerto I Yes 2 X No specify: Decedent's Usual Occupation (Give kind of Yeduring most of working life DO NOT use reference.)	pecify Yes or No- Rican, etc.)	10d Inside City Limits 1 X Yes 2 No Citizen of What Country? U.S.A. 14 Race - American Indian, Black, White, etc. Specify. White bb. Kind of Business/Industry Restaurant				
-003 withing giene her the	E I	11 17. Father's Name (First, Middle, Last)	Waitress 18 Mother's Name	(First, Middle, Mai					
21215-0036 uld be filed within 7 Mental Hygiene marked other than	Be C	Thomas L. Barlow		M. Brewer	,				
e, MD 2121 and 2 should be fi feelth and Mental 1 item 27 is marked traumatic event,		19a. Informant's Name/Relationship (Type, Print) John J. Wilson (Son)	9b. Mailing Address (Street and Number or I 155 Summer St. Hager	Rural Route Number, City or Town, State, Zip Code)					
2 2 5 E 5		1 Burial 2 XCremation 3 Removal from State crema 4 Donation 5 Other Specify:	sburg Crematory 14	ecember , 2006	Oc. Location - City or Town, State Smithsburg, Maryland				
Baltimo permit. Page Department of Important: injury or ott	1	21 Signature of Funeral Service Licensee Davis MO1414	22. Name and Address of Facility		is Funeral Home				
Physician	=	23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.	12525 Bradbury Avo	r respiratory arrest,	shock, or heart Approximate Interval Between Onset and				
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Pro x hene and me robamate intoxication Due to (or as a consequence of): b								
cecuted and transit	l Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.							
o, e be exec ysician ar burial - t	dica	XUNPENDED = 423a, 27, 28a-	-f. perME. g863, 1/5/07 TT						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.		IF FEMALE: 23c. If yes, outcome of pregnancy	ancy	23d Date of delivery Month Day Year					
P.O. E es that the cigned by the detached	ক্র	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown				
Records, The law requir cate has been s	Completed			24a. Was an autopsy performe					
tal F	8	25. Was case referred to medical examiner?	26 Place of Death (Check						
of Vir	의	1 ✓ Yes 2 No	Outpatient 3 DOA Other Nursin	ng Home 5 Re 28d Describe how	sidence 6 Other.				
Division of Vital Records, P.O. rate dor attending Physician: The law requires that the rapher death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached in the funeral director.	Certification:	1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 X Could not be determined	15:30 pm 1 Yes 2 No farm, street, factory, office building, etc.	unknown 28f. Location (Stre or Town, State	et and Number or Rural Route Number, City				
To the Hospita within 24 hours To the Funera completely fille	Medical Ce	4 Homicide (Specify) home 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.) and manner as stated				
F & F 8	Me	29b. Signature and title of certifier Other Completed Cause of death (Item 23a) 30. Name and address of person who completed cause of death (Item 23a)	29c License number O.C.M.E.		9d. Date signed <i>(Month, Day,Year)</i> December 9, 2006				
		Patricia Aronica-Pollak MD. Assistant Medical Exam	miner 111 Penn Street, Baltimor	re, MD 21201					
Sta Registi		31. Date filed (Month, Day, Year) DEC 1 8 2006 32 legistrar's Signature	freezer						

	•	For Stata Registrar	5	State of N	Marylar	-		nt of H <i>te of L</i>		ind M	- '	giene leg. No.	006	40247	
Physicia		Decedent's Name (First, Middle	e, Last)	Wilhi	ır L. (reek.					2. Date of Dea Month	Day	Year	3. Time of Death	
/Medic Examin		4a. Facility Name (If not institution	n, give stre			JICCK	4b. Cit	, Town, or	Location of	f Death	No	v 24, 20 4c. Co	unty of Death	1800 "	
LXamii		Anne Arur	ndel Me	edical Cen	ter				Annap	olis			Anne /	Arundel	
Funeral		5. Social Security Number	6. Sex	7. /		last birthday)		er 1 Year	If Under 2	24 Hrs.	8. Date of Birt	Yaari		plece (State or Foreign intry)	
Director		219-54-4689	1 ∑ N	4 2□F	57	Yrs.	Months	Days	Hours	Min.	(Month, Day	, rear) 5, 1949		Maryland	
D		Usual Residence of Decedent										, 12 10			
trylar	_	10a. State 10b. County			10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
Ba-fs	cto	MD Prince George's Bowie									1 Tyes 2 No				
or 2	Director	10e. Street and Number 10f. Zip Code								10g. Citizen	of What Cou	,			
ath w	ra	16612 Queen Anne Bridge Rd. 20716 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?									U.S./				
tams	Funeral	11. Marital Status		Armed Forces	s?		Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Orig n, Mexican,	in? (Spe , Pu <i>er</i> to F	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White		
s afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	- 1	1 Yes 2 [If Yes, Give Year or Dates			1 🗆 Yes	2 💢 No	Specify:			Sp	ecify: Blac	·k	
If a last 15-0050 filed within 72 hours after death with the Maryland Hygiene. Hyer than "natural", or Itams 23a or 28a-f show ant, the Macical Examiner must be notified at		15. Deceden			· 19	971 16a. Dece	dant's Lie	ual Occupa	ation			16h Kind	of Business/Ir		
n 72 n 72 n 72	Completed	(Specify only highe		completed)		(Give	kind of w	ork done d use retired	luring most	of working	ng	TOD. KING	01 003111033711	idustry	
withi ene. than	mg	Elementary/Secondary (0-12)		College (1-4o	r 5+)		D	ump Tr	uck Driv	ver			Constru	ection	
a filed I Hygi other ent, I	ŭ	17. Father's Name (First, Middle,	Last)			1		ump m			(First, Middle.	Maiden Sui			
yidiid buid be filed Mental Hyg arked other attc event, i	To B		Ma	urice Cre	ek Sr			1			Не	elen Co	ntee		
aryid should and Men is marke sumatic	F	19a. Informant's Name/Relations			OK 01.	19b. Mailir	ng Addre	ss (Street a	and Number	r or Rurai	Route Numbe			p Code)	
and 2: alth ar n 27 is		Nancy Creek/wife									Bowie, MD				
D - 3 2 2		20a. Method of Disposition			20b. I	Place of Dispo	sition (N	ame of			ate		ion - City or T	own, State	
diffinor mit. Pages partment of portant: If it y injury or o		1 Burial 2 Cremation 4 Donation 5 Other (5		noval from Stat	le l	cemetery, crei			1	11/2	30/06		Challanh	om MD	
DESILITION permit. Page Department of Important: If Important: If any Injury or Once.		21. Signature of Funeral Service		Ω	Cn	eltenham \			s of Facility		50/00		Cheltenh	am, wid	
Department of the popular of the pop		Iladen C	7	ernel.	e		Se	well Fu	ineral H	lome					
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): ASPINATION PRIVATION B. Sequentially list conditions.													
cate be executed cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or a	as a consec	quence of): I			10ma	_					
death certifi death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	: If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of c	al death 3	Ectopic Other (pregnancy specify)				23d	23d. Date of delivery Month Day Year		
ords, F.C. requires that the een signed by th hould be detache	by P	Part II. Other significant conditi	ons contri	buting to death	but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use	co use contribute to the cause of death?		
equire en sig											1 🗆 Y	es 2	2. No 3 Probably 4 Unknown		
The lar	Completed					-				_	24a. Was autop perfor 1 \(\text{Yes} \)	sy /	ed? prior to completion of cause of death?		
Or VICAL F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?		- 12-12						of Death	(Check only o	1e)			
sign of the state	ို	1 ☐ Yes 2 ☐ No	Hos	spital: 1 mpa		ER/Outpatier			4 🔲 1901		ne 5 Resid			fy)	
on on ding Phy th. After thi funeral o	on:	27. Manner of Death 1 Natural 5 Pendir	na	28a. Date of Ir (Month, I	njury Day Year)	28b. Time o Injury		28c. Injury Work			8d. Describe h	ow injury o	ccurred		
SIO eath. or: A	catl	2 Accident investi	-				М	1 🗆 '	Yes 2□N						
UNISION tal or Attending s after death. al Director: Afte ed in by the fune	Certification;	3 Suicide 6 Could 4 Homicide determ	28e. Place of l building,	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Pl Within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physic Examine	r: On the bears and manner	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	ne, date and pinion, deat	d place, a h occurre	nd due to the d ed at the time, d	ause(s) and late and pla	d manner as s ice, and due t	stated. to the cause(s)	
To t To t	Σ	29b. Signature and title of certifie	r				2	9c. License	number			/	gned (Month,		
		MOON	Mra	ical h	Diplace	MIT		D	644	181		11/2	4100	0	
5/1		30. Name and address of person			f death (Ite	m 23a) (Type,	Print)		A		1	1.~			
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Sta Registi		31. Date filed (Month, Day, Year,	4	32. Regis	strates Signa	ature	do	we		ı					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene 1- State of Maryland Department of Health and Mental Hygiene 1- Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dec 9, 2006 Clemons 5:55 am Curtis /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 18603 Coco Road Oldtown If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1923 1√ M 2□ F Aug 30, Director 214-26-6588 83 Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits oriant: if item 27 is marked other than "naturel", or item e 23a or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at Oldtown MD Allegany 1√ Yes 2 No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 18603 Coco Road 21555 by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 General Motors Plant ₋aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18603 Coco Road MD 21555 Versie Clemons wife Oldtown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 12/12/2006 Baltimore Baltimore National Cemetery MD 4 Donation 5 Other (Specify) 21. Signature of Fuheral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enter one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): ed by the attending physicien and deteched for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arterial 1 Yes 2 No 3 Probably 4 Unknown Thrombi 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 200 Kena Mrombosis 1 Yes 1 🗆 Yes To the Hospitel or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00064167

State Registrar

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

COMBERLAND

MD

MD

32. Registrar's Signature

N. QAISRANI

VIRGINIA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUE

8 2506

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Vee William Francis Drummond 2 00 06 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Brookfield Manor Assisted Living Keymar Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Days Months Hours 1**⊠** M 2□ F 89 Yrs. Mar 31, Ohío 10c. City, Town or Location 10d. Inside City Limits Westminster Carroll 1 MYes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 395 Kingsbury Way #32 21157 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Mayes 2 □ No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: white Specify: WWII 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Foreman 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James B. Drummond Mary Gallagher 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice L. Drummond, wife 395 Kingsbury #32, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/02 1 Burial 2 □ Cremation 3 Removal from State Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Myers-Durboraw Funeral Home M01191 91 Willis Street, Westminster, MD 21157 Zussor 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death ears Due to (or es a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? 2X No 1 🗆 Yes .≱ □ No 1 Tyus Living

Physician /Medical

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

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filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28e-f ehow

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

5. Social Security Number

Usuel Residence of Decedent

12

20a. Method of Disposition

285-03-9098

10e. Street and Number

10a. State

Maryland

11. Marital Status

Examiner Physician/Medical þ Completed Be ဥ

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Examiner attending physicien end I for use es the buriel-transit The lew requires that the death certificete be executed page 2 should be detached Š hes certiticate Hospital or Attending Physician: After this funeral To the Hospital or Attending within 24 hours efter death.
To the Funerel Director: Afte completely filled in by the fun.

Division of Vital Records, P.O. Box 68760,

MJL ioti VA State

Immediate Ceuse (Final diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Certification:

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Naturel 5 Pending 2 Accident

(

31. Date filed (Month, Dev. Year)

3 ☐ Suicide

29a. Certifier

d

4 Homicide

Hospital: 1 Inpatient 28e. Dete of Injury (Month, Dey Year) investigetion 6 Could not be determined

2 ER/Outpatient 3 DOA 28b. Time of

М

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26. Place of Death (Check only one) Chas ested Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

9522

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

auco 30. Nem-y and eddress of person who completed causa of deeth (Item 23e) (Type, Print)

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PRICO



DHMH 16 Rev 6/95

Registrar

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	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last, Rebecca J. 4a. Facility Name (If not institution, give	Dana hi street and number)		. Ka	C		r Location of		2. Date of Dea Month 1 2	Day O 3	Yea 3 20 County of D	eath	Time of Death
	Funeral Director		5. Social Security Number 6. Sec	ice at the x M 2 M F 7. Age		last birthday) Yrs.		ler 1 Year s Days	If Under 24 Hours	Min.	3. Date of Birt (Month, Day 7-15-19	h /, Year)			(State or Foreign
	be filed within 72 hours after death with the Maryland Hygiene. d other then "neturel", or items 23a or 28a-f ehow event, the Medical Exandian minut be notified at	Director	10a. State 10b. County 10c. City, Town or Location DELAWARE SUSSEX FRANKFORD 10e. Street and Number 10f. Zip Code												nside City Limits ☐ Yes 2X No
39		by Funeral	24834 BLUEBERRY L. 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 № No Specify:					US 14. Race - American Indian, Black, White, etc. Specify: WHITE			
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ď			PEARL R. DONOHUI 20a. Method of Dispesition 1 Burial 2 Dispesition 4 Connation 2 Other Section	Sition (Notation)	HENLOPEN 12-4-06 FRANKFORD, DELAW										
			21. Signature of Funeral Schools Licens 23a. Part1. Inter the dise see or compleshock, or heart failure. List only or Immediate Cause (Final	ications that caused	the deat	h. Do not ent					CES, LTI ORO, DI		9966	Inter	roximate val Between et and Death
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		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 250 No 9 □ Unknown	3c. If yes, outcome of	Pregnant at time of death 5 Other (specify)					FICHTON AS	ARPROVED BY MEDICAL EVANIMER 23d. Date of delive Month			delivery Day	Year
Records, P	v requires the been signed should be de	Completed by Pr	Part II. Other significant conditions cor	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								id tobacco use contribute to the cause of death? Yes 20 No 3 Probably 4 Unknown as an 24b. Were autopsy findings available			4 Unknown
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			1. Decedent's Name (First, Middle	, Last)					2. Date of Death		3. Time of Death			
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}	/Medic Examin		4a. Facility Name (If not institution		1	r Location of Death		4c. County of Dea						
			Shock Traum	na Cen	ter		Balti	imore		Baltimo	ose City			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bii	rthplece (State or Foreign ountry)			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.	ı	20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)						20c. Location - City or Town, State			
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Sic	death tor: the f	cat	2 Accident investig	not be	129106	1920		Tes ZINO		deun St	airs			
Division	for Attendent effer deatl	Certification:	4 ☐ Homicide determ	ined 286. Pla buil	ding, etc. (Spec	uty)	reet, factory, office		City or Town	State) 3009	Ramblewood Rd			
_	a sa p		29a. Certifier 12 Certifyir	g Physician: To I	he best of my kn		th occurred at the to	me date and place	Ellicott C		21047			
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	Hospit 24 hour Funere stely fills	dicai	(Check only 2 Medical one)	and ma	basis of examinance stated.	nation and/or in	ivestigation, in my o	opinion, death occui	irod at the tanto, do	p ,	e to the cause(s)			
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	To the Hospital or Attending Physicien: The within 24 hours effer death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	one)	and ma	basis of examinance stated.	nation and/or in	29c. Licens	se number	29		` '			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Year Day **EDWARD** THOMAS DANNER, SR. December 7, 2006 9:05 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Allegany** Memorial Hospital Cumberland If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 ▼ M 2 □ F 214-05-5636 12/7/1914 Maryland 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 ∑Yes 2 ☐ No Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 1719 Frederick Street 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify WWII Specify. 3 ☑ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Union 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mae Bachman Charles Easter Danner Louisa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Danner, Jr. / son 1046 Weires Avenue, LaVale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 12/11/2006 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 21. Signature of F neral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502

Physician /Medical **Examiner**

burial-transi

signed by the attending physician the detached for use as the buria

page 2

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

within 24 hours a To the Funeral L

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The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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"natural", or items 23a or 28a-f shov edical Examiner must be notified at

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d 2 should be filed w h and Mental Hygiel ? is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

shock, or heart failure. List only	y one cause on each line.			or respiratory are		Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)	a. CORONARY ART		Oliset and Death				
On word all will at an addition	h						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq						
that initiated events resulting in death) Last	Due to (or as a conseq						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	23d. Date of deliv Month	very Day Year				
Part II. Other significant conditions CEREBROVASCULAR A	•	ulting in the underlyin	g cause given in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to t s 2 ™ No 3□ Pro	the cause of death? bably 4 Unknown	
		-		24a. Was an autopsy perform 1∐ Yes 2	y prior to co ned? death?	opsy findings available ompletion of cause of	
25. Was case referred to medical			26. Place of De	eath (Check only one	9)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 □	Home 5 ☐ Reside	ence 6 ☐Other (Specify)				
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, fac y)	tory, office	28f. Location (Str City or Town	tion (Street and Number or Rural Route Number, or Town, State)		
	Physician: To the best of my kno aminer: On the basis of examina and manner stated.						
29b. Signature and title of certifier			29c. License number	d. Date signed (Month,	Day, Year)		

DHMH 17 Rev 1/2001

×

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEC 0 8 2005

31. Date filed (Month, Day, Year)

S. Gupta, Johnson Heights Medical, Cumberland, MD 32. Registrar's Signature

D33280

December 8, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 23a Lineb, 19a, MLU 12/06/06, Allegany County Per Phy State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 0 I Myrtle V Edmunds 1120 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS Braddock Campus Cumber land Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2**X**) F 213-18-2668 87 Director 1919 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Director MINERAL RIDGELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26753 U.S.A. 40 BLOCKER STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by WHITE 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSING NURSING ASSISTANT UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental } ANNA CATHERINE MILLER HENRY KEIPER 19a. Informant's Name/Belationship (Type, Print)
Edmunds
EARL O. EDMUNS/STEP—SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 79, ARNOLD, MD 21012 If Item 27 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) LORRAINE PARK CEMETERY 12/08/2006 BALTIMORE, MD 21. Signature of Funeral Service Licenter 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** intestinal Viscous /Medical Examiner Small Bowel Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical use as attending) for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown Part II. Other 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 No 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 20 No 1 Licoatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and till of certifier OK Par Doubs 3 on D- Cumberland are eath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State DEC 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink.' Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #5 Per FH G862 12/26/06 JH Grifficate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Voar **Physician** CYNTHIA FLESHER DECEMBER 2006 1740 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Winchester Road CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sep 19, 1989 Birthplace (State or Foreign Country)
 MD **Funeral** 17 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show MD Allegany Rawlings permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important If Item 27 is marked other than "natural", or Items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2√☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21557 USA 19830 Copperhead Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ **X**o Baltimore, Maryland 21215-0036 Specify: \$ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student High School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gene Flesher Annette (Fuller) Flesher ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19830 Copperhead Road Rawlings MD 21557 19a. Informant's Name/Relationship (Type. Print) Gene Flesher father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/15/2006 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 1 108 Virginia Avenue: Cumberland, MD 21502 23a part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Motor **Physician** Vehic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1⊠Yes 2□No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Multiple 28c. Injury at Work? injuries, motor vehicle 1 Natural 5 ☐ Pending investigation Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 XNo 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) E Winchester Road 28e. 4 Homicide Cresaptown, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29 Signa re and title of certifier

Registrar

DHMH 17 Rev 1/2001

6

State

Day, Year)
C 1 8

2006

. Registrar's Signature

of death (Item 23a) (Type, Print) MEMONIAL HOSPITAL

CUMBENIAND MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 40255

			1 - For State Registrar	otato or marytano /		tificate of			, ,	g. No.	
	Dhamini		1. Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		Katherine M. Fol	.k				De	cember	•	2:45 P M
	Examir		4a. Fecility Name (If not institution, give s			4b. City, Town, o	or Location of	of Death		4c. County of Dea	th
			2582 Bear Den Roa			Frede				Freder	
	Funeral		5. Social Security Number 6. Sex	M 2 RAE	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		578-42-8321 Usual Residence of Decedent	76	113.			Fe	b. 4,	1930 New	York
	land ow		10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Man,	ğ	Maryland Frederi	ck Free	deri	ek					1 ☐ Yes 2 No
	or 28g	Director	10e. Street and Number		-	10f. Zip Code			10	g. Citizen of What C	ountry?
	th will	aiD	2582 Bear Den Road			217	701		Un	ited Stat	es
	eep r	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cub	lispanic Original	gin? (Specify	Yes or No- an. etc.)	14. Race - Am Black, Whi	erican Indian,
36	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23a or 28a-1 show the Modical Exerting reset to notified at	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 ⊠ No If Yes, Give	1	☐Yes 21 No				Specify: Wh	
8	hour tural	d be	3 Widowed 4 Divorced	Year or Dates:	a Deced	ent's Usual Occup	ation			6b. Kind of Business	
21215-0036	n n	Completed	(Specify only highest grade	completed)	(Give I	kind of work done OO NOT use retire	during mosi	t of working	'	ob. Airo of business	inoustry
212	d with piene.	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	ırcha	sing Ag	gent		G	overnment	
힏	otha vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (F	irst, Middle, M	aiden Sumame)	
Jai	Venta	ToE	Percy Mansfield				Ethe	el Re	ynolds		*
Maryland	2 sho and 1 Is me	0 4	19a. Informant's Name/Relationship (Ty							City or Town, State,	Zip Code)
≥	and ealth m 27		John Folk/ Husband			ear Den	Rd, F	A-10-0			
Ore	P of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		of Dispos ery, crem	sition (Name of patory or other plac	ce)	Date	_	Oc. Location - City or	Town, State
<u>=</u>	tmen tant:		4 □ Donation 5 □ Other (Specify)	Frede	rick	Cremato	1 V .	2/5/20		ederick,M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-1 ehow any injury or other treumatic event, the Medical Exaction must be notified at ance.		21. Signature of Funeral Service Licent	90	22	Name and Addre	ss of Facilit	yStauf:	fer Fur	eral Home	, P.A.,
	40204		23a. Part 1. Enter the disease, or compli	cations that caused the death. De						erick, MD	
		n d	shock, or heart failu List only or Immediate Cause (Final	e ause on each line.					spiratory arres	5t,	Approximate Interval Between Onset and Death
	Physician / /Medical	i i	disease or condition resulting in death)	13 -010		meta	sca	5=5			
	Examiner			Due to (or as a consequence	e of):	meta C.					201 -
		je.	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or se s consequence			-14 (-			204-3
	rtificate be executed ng physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events								
o	en ar	Ψ.	resulting in death) Last	Due to (or as a consequence	e of):						
68760,	ate be nysici he bu	Medical									
	e as t		IF FEMALE:								
Box	death ce e attendi	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea		Ectopic pregnancy	1			23d. Date of de Month	livery Day Year
P.O.	he de the s	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5	Other (specify)					
	The law requires that the death ce ite has been signed by the atlendi bage 2 should be detached for use		Part II. Other significant conditions con	tributing to death but not resulting	in the un	derlying cause giv	en in Part I.		23e. Did toba	icco use contribute to	the cause of death?
Division of Vital Records,	uires sign Id be	d by							1 ☐ Yes	2 ■N o 3 □ Pi	robably 4 Unknown
000	w req	Completed							24a. Was an	24h Wara a	utopsy findings available
Be	The lay	E C							autopsy perform	prior to death?	completion of cause of
ta	hysician: The his certificate i director, pag	a)	25. Was case referred to medical				26 Place	of Death /C	1 ☐ Yes 2		2 □ No
\leq	Physici this cer al direct	To B	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient	3□ DOA Oth	or.			ce 6 □Other (Spe	cify)
0	ding Ph h. After th funeral		27. Manner of Death 1 €Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of	28c. Injur Wor				injury occurred	
<u> </u>	Attending Physician: or death. sctor: After this certifics by the funeral director. I	Certification:	2 ☐ Accident investigation	,,	,uiy		Yes 2 ☐	No			
Ĕ	l or Attendente destination by the	ŧ	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office		28f.	Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
Ω	urs ef										
	To the Hospital or Attending Ph within 24 hours effer death. To the Funerel Director: Atter th completely filled in by the funeral	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my knowledger: On the pasts of examination a and manner stated.	ge, death ind/or inv	occurred at the tire estigation, in my o	ne, date and pinion, deal	d place, and th occurred a	due to the cau at the time, dat	ise(s) and manner as e and place, and due	s stated. to the cause(s)
	ithin ithin or the comple	Mec	· ·			29c. Licens	e number		290	d. Date signed (Mont	h, Dav. Year)
	r > ⊢ ŏ				» مسر ا	01	462			Derc	2001
	in		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type. F	Print)				,	, , , , , ,
	12		OPG Trau.	sch MD 5	0/	un	350	7	Fred	10-1051	7 / 2/70/
	Sta		31. Date filed (Month, Day, Year)	32. Pagistrar's Signature							
	Registi	ar	DEG (5 20	mpleted cause of death (Item 23a 5 5 9 32. Pegistrar's Signature	A	ents)					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 29, 2006 Frances D. Feger 7:15pm M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8525 Marybeth Way Ellicott City Howard If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 12/14/1921 1 □ M 2 🔀 F Maryland 84 216 18 6546 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 USA 8525 Marybeth Way 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Irene White Frank Wurz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ellicott City, MD Frankye Hile/daughter 8525 Marybeth Way 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Pk. 12/2/2006 Elkridge, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01442 ermia Ellicott City, MD 21043 4112 Old Columbia Pike Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause up each line. immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonscollenou of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical **Examiner**

> and burial-tran

ed by the attending physician detached for use as the burial

is been signed by the should be detache

certificate has page 2

this

After t

hin 24 hours after death the Funeral Director:

or Attending

funeral director,

filled in by

2

Completed

Be

Certification: To

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

<u>ک</u>

Completed

Be

ဂ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

1 and 2 should be filed within 72 hours after whealth and Mental Hygiene.

Pages 1 and 2 rement of Health a tant: If Item 27 It

permit. Page Department o Important: If any Injury or

ortant: If I

Baltimore, Maryland 21215-0036

death with the Maryland

Examiner Physician/Medical

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an

BURNIE MOZIOGO

2 **N**0 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

State Registrar

501

31. Date filed (Month, Day, Year) DEC 04 2006

5 Pending investigation

6 ☐ Could not be determined

25. Was case referred to medical examiner?

1 Yes 2∑ No

Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

gistrar's Signature

5

			For State Registrar	State of Maryla		partment of I ertificate of		-	giene 0 0 6	5 40257
			Decedent's Name (First, Middle, La.	st)				2. Date of De	ath	3. Time of Death
	Physici /Medio		Anna	Margaret Ge	sell			Decemb	per 1, 20	06 8:45 P ^M
}	Examir		4a. Facility Name (If not institution, give		- 1- 1-		or Location of Deat		4c. County of De	
	Formeral		Brinton Woods 5. Social Security Number 6. S				Sykesvi If Under 24 Hrs		Carrol	. L Birthplace (State or Foreign Country) MD
П	Funeral Director			□M 2XF 81	Yrs	Months Days	Hours Min.	8. Date of Bir (Month, Da May 4	1925 We	Country) MD estminster,
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or	Location				10d. Inside City Limits
	Aaryla f ehor	ច		2.2		ninster				1 ☐ Yes 2 ☐ Yo
	r 28e-	rect	10e. Street and Number	1011	MESCI	10f. Zip Code			10g. Citizen of What	Country?
	th with	ai D	1200 Long Val	ley Road		211	58		U.S.A.	
	tems tems	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 1	 Was Decedent of H If Yes, specify Cub 	Hispanic Origin? (S ean, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Race - A Black, W	merican Indian, hite, etc.
36	72 hours after death with the Maryland natural', or flems 23a or 28e-f ehow disal Examilinar must be motified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
5-003	"natural"		15. Decedent's Ed	ducation	16a. De	cedent's Usual Occupive kind of work done	pation		16b. Kind of Busine	ss/Industry
7	E c 9	Completed	(Specify only highest gra	College (1-4or 5+)	inte	 DO NOT use retire 	during most of wo	rking		
121	filed within I Hygiene other than rent, the Me	Ö	12 17. Father's Name (First, Middle, Last)		N	ırse Aid	19 Mother's Na	ne (First Middle	Medic Maiden Sumame)	al
Maryland	d be ental ked c	To Be		rry Bucking	ham				th Dell	
ary	A DE E	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma		and Number or Ru	ıral Route Numbe	er, City or Town, State	a, Zip Code) 21158
	and 2 ealth a n 27 le		Margaret Carol				Long Va	alley R	d. Westm	inster, MD
ore	Pages 1 and nent of Health int; If Item 2 iry or other I		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, c	sposition (Name of crematory or other pla	(ce) 12/3	3/2006	20c. Location - City	
altimore,	rtmen rtant; njury		4 Donation 5 Other (Specification 21. Shipparties of Funeral Service Licer		uth (Carroll (Winfie	ld, MD
Ba	permit. Page Department of Important; If eny injury or		Tusti R. D	10M Zuarolu	191	Myers-Du 91 Willi	irboraw is St.		l Home nster, M	D 21157
		/	23a. Par 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not	enter the mode of dyi.	ng, such as cardia			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		Cardiomy	opothy			Onset and Death
ı	Examiner			Due to (or as a conse	quence of);	,	1			
	₽ ≒	ner	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying	Due to (or as a consu	quence of):					
	and errans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse	uneuce ot).					
8/60,	eath certificate be executed attanding physicien and for use as the burial-transit	dical E		d	423.133 3.7.					
9	tifficate ng phy as the									
ROX	death certif e attanding id for use a	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet		3 □Ectopic pregnanc	у		23d. Date of o	delivery Day Year
0	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death	5 ☐ Other (specify) _			147071111	Day Toal
1	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	e underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	w require been sig should b	ed b						101	res 2⊡No 3□	Probably 4 Unknown
ဗ္ဗ	law ranga banas be	Completed						24a. Was autop	sy prior t	autopsy findings available o completion of cause of
	t; The law icate has r, page 2 s			· · · · · · · · · · · · · · · · · · ·					rmed? death 2 No 1 Y	7 es 2□ No
Vita	Physiclan; Tribis certifical	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpat	tient 3 DOA Ott		ath (Check only o		
סר	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injur	of 28c. Inju			dence 6 Other (S)	oeciny)
<u> </u>	death. ctor: Afr y the fur	atio	1 Natural 5 Pending 2 Accident investigation	n	Irijai		Yes 2 □No			
DIVISION	. 후 로 원	Certification;	3 Suicide 6 Could not be 4 Homicide determined		nome, farm, ify)	street, factory, office		28f. Location (5 City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: / completely filled in by the fi		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, de	eath occurred at the ti	me, date and place	, and due to the	cause(s) and manner	as stated.
	he Ho in 24 h he Fu pletely	Medical	(Check only 2 Medical Exan	niner: On the basis of examinand manner stated.	ation and/or	investigation, in my o	opinion, death occu	irred at the time,	date and place, and d	ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	(gul mo		29c. Licens			29d. Date signed (Mo	
	MIL				m 00-1 m		059943		December	- 2,200G
	. 7		30. Name and address of person who	295 Stoney	A CIVE	Suite 30	or west	minster	MO 21	157
3.	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4	2006 32. Registrar's Sign	ature	Suite 30		,		

Amended Item 29a per M.E. 12/04/2006 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 29 2006 7:50 P. M Samuel H. Giacolone Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Senior Constant Care Winfield Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 20, 1917 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1X M 2 □ F 069-05-2858 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Carroll Winfield Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1200 W. Old Liberty Road 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 123 ves 2 □ No 1942 − 17 ves, Give Year or Dates: 1945 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2☐No Specify: Completed by 3XXVidowed 4 ☐ Divorced 1945 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County State Elementary/Secondary (0-12) 10th College (1-4or 5+) Roads General Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2516 Old Washington Road Westminster, MD 21157 Stepson Louis Bernier, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet. Cem. Dec. 8, 2006 Garrison, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Sykesville, MD 21784 21. Sign Tuny of Funeral Service Licen & Crematory, MI) Z.
Sykesville, MI) Z.
Approximate Interval Between Onset and Death
Years 23a. Fart1. Inter the disease, or complications that of sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e ock, or heart failure. List only one cause on or chiline. Imme reter ause (Final disease of condition resulting in death) Alzheimers' Disease **Physician** 5 y<u>ears</u> /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) Physician/Medical the ! IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a Was an autopsy performed?

1 Yes 2 XNo 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28d. Describe how injury occurred Fell getting 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 ☐ Pending investigation Injury 1800 1 ☐ Yes 2 No 2 Accident 11-19-00 up from filled in by the 6 Could not be determined 28f. Lo. ation (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Winfield Facility Assisted Living Liberty W 1200 Dertifying Physicians: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician cate has been signed by page 2 should be detach certificate has or Attending Physician: this After t within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

WJL 6TIVA

29b. Signature and title of certifier M.K. MEGVOY 31. Date filed (Month, Day, Year)

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1380 Progress Wa

32. Registrar's Signature

DEC 0 4 2006

Registrar

29c. License numbe

D33681

Elders bury

40259

1	-	For State Registrar

			1 - For State Registrar			Cei	tificate of	Death	morna, my	Reg. No.		1 UF WAS
	D		1. Decedent's Name (First, Middle	, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Catherine	Mary	Greg	ory				er 30,		4:25 P M
	Examin		4a. Facility Name (If not institution	, give street and numbe	r)	_	4b. City, Town, o	r Location of Dea	ith	4c. Count	y of Death	
			Calvert County					Frederi			lvert	
П	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 ☒ F		last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bir (Month, Da	th ay, Year)	Coun	lace (State or Foreign try)
	Director		579-03-5283		90	Yrs.	s. Months Days Hours Min. June 2, 1916 Pennsy					
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1-	0d. Inside City Limits
	Mary	ō	MD Cal	vert		Chesar	eake Bea	ch				1 X Yes 2 □ No
	ith the Marylar or 28a-f ehow	Director	10e. Street and Number	.,,	1		10f. Zip Code			10g. Citizen of	What Coun	try?
	3a oi		8415 F S	Street			2	0732		U.	S.A.	
	filed within 72 hours after death with the Maryland Hygiene. Nifer then "natural", or Items 23a or 28a-f ehow ent, the Medical Examinar must be notified.	Funeral	11. Marital Status	12. Was Deceder		.S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Specify Yes or No	o- 14. Ra	ce - Americ	
5	after or Its		1 Never Married 2 Marri	Armed Forces					πο Hican, etc.)		ack, White,	
3	ral.	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates	:		1□Yes 2XX No	Specify:		Speci	'n∵ wn	ite
5	72 h Inatu	Completed	15. Decedent (Specify only highes	's Education it grade completed)		(Give	dent's Usual Occup	during most of w	orking	16b. Kind of 8	Business/Inc	dustry
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7	tygie her t		17. Father's Name (First, Middle, I	(nat)		printi	.ng procu			U.S. go		ent
	be fi	Be							ame (First, Middle Cathe:		<i>™⊕)</i> Kidder	
Š	should be nd Mental marked c	2	Charles Pric			105 14-15-	- Add (Chara	Mary				
	d 2 st th and 7 te r		19a. Informant's Name/Relationsh				rg Address (Street F St., C					Code)
ב ט	ges I and 2 should be filed within 72 hours after death with the Maryla tof Health and Marala Hygiens in attural; or items 23a or 28s-1 ehov If item 27 is marked other then "natural; or items 23a or 28s-1 ehov or other traumatic event, I'm Madical Examinar must be notified at		Fontaine Disney 20a. Method of Disposition	, SOII	20b. P	A STATE OF THE PARTY OF THE PAR			Date	20c. Location		wn Slate
5	ages nt of nt of :: If it		1 🗆 Burial 2 💢 Cremation				sition (Name of natory or other place					
	a first of the Carlo		4 □Donation 5 □Other (Sp 21. Signature of ¶uneral Service I		Meti		an Crema		01/2006	Alexand	iria,	VA
2	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra		1 100	\Rightarrow	h-		ausch Fu	A9409V94	ma D A	Control	= Mn	20736
		-	23a. Part1. Enter the disease, or	complications the caus	ed the deat						3, FID	Approximate
			. shock, or heart failure. List in mediate Cause (Final	only one cause on each	line.							Interval Between Onset and Death
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ı	Examiner			A H24	s a conseq	uence oi):	Hic Co	odin 1	monula	n of its	200 6	
		ē	Sequentially list conditions, if any, leading to immediate	b. // Due to (or a	is a conseq	uence of):	or co	11(1100	us will	01 411	co se	
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	.								
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3	ing ph	Medical		1-00								
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	deal ed fo	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown			Other (specify)			М	onth	Day Year
	at the	Physician/	9 Unknown									
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5	sen s	Completed	1921 LI	184 Bler	1CY				1 🗆	Yes 2□No	3 🗆 Prob	ably 4 ⊡Onknown
5	as be	pie							24a. Was	an 24b.	Were autor	osy findings available inpletion of cause of
=	The ate h	Son							perfo	rmed? 2 ☑ No	death?	2□ No
9	entific ector,	Be	25. Was case referred to medical examiner?						ath (Check only			
5	hysi this c	P	1 ☐ Yes 2 ☑ No			ER/Outpatien			Home 5 ☐ Resi)
	Ing P	on:	27. Manper of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	Wor		28d. Describe	how injury occu	rred	
2	ttend death tor: /	cat	2 Accident investig	not be				Yes 2 □ No	00/1			
2	s after or All Direct of In Dir	Certification:	4 Homicide determi	ined 289. Place of I	njury - At no etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office		City or To		ber or Rurai	l Route Number,
	To the Hoepital or Attending Physician: The law requires that the death ce within 24 hours after death cell within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	edical (29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the bes Examiner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred at the tir	me, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as st	ated. the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		~		29c. Licens			29d. Date signe	ed (Month, L	Dey, Year)
			Lega	-c.8	m	cr_	D	5065	3	Decembe	er 1,	2006

5 State Registrar

Gyan Surana, M.D., 5851 Deale Churchton Rd., Deale, MD 20751 31. Date filed (Month, Day, Year) 32. Registras Signature 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11/25/2006 Goldman 1400 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X**M 2□ F Director 674-10-5338 79 8/28/1927 Russia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Director Montgomery Gaithersburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7903 Plum Creek Drive 20879 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 【XNo Specify: Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 4 College (1-4or 5+) Elementary/Secondary (0-12) Engineer Civil 17. Father's Name (First, Middle, Last)
Efim Goldman 18. Mother's Name (First, Middle, Maiden Surname) Be Galya Mazur ပ 19a Informant's Name/Relationship *(Type Print)* Tatiana Alperovitch – Daughter 19b Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zin Code) 7903 Plum Creek Drive Gaithersburg MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 11/28/06 4 Donation 5 Dother (Specify) Arlington Mem. Park Atlanta - GA 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc. 21. Signature of Funeral Service License 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRO VASCULAR **Physician** DAYS disease or condition resulting in death) a HEMORRHAGIC /Medical Due to (or as a consequence of): Examiner HYPERTENSION Esqueritions in terruitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PNEUMONIA The law requires that the death certificate be executed DAYS and burial-trai Due to (or as a consequence of): Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy perform certificate 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a NOVEMBER 25TO, 2006

9901 MEDICAL CENTER DRIVE

ROCKVILLE

MD

Registrar

State

NIDHI

31. Date filed (Month Day)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O.

SINGH

and address of person who completed cause of death (Item 23a) (Type, Print)

NIKHANI

MD

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

			For State Registrar	State of Ma	arylano / L		irtment of H tificate of I			eg. No.	06	40261
	Dhusisi		1. Decedent's Name (First, Middle, La	ist)			1		2. Date of Dear	-	Year	3. Time of Death
	Physici /Medio		Margaret Angel	a Gannon					Novembe	r 25,	2006	1:00 a ^M
	Examir	er	4a. Facility Name (If not institution, gr	re street and number)		ľ	4b. City, Town, or	Location of Death	h	4c. Count	y of Death	
			Montgomery Gener				01ney				tgome	
	Funeral		· ·	Sex 7. Ag 1 □ M 2 ②XIF	e (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	9. Birthr	place (State or Foreign ntry)
	Director		189-30-5754 Usual Residence of Decedent		65	113.			Feb. 21	, 1941	Pen	nsylvania
	land ow		10a. State 10b. County		10c. City, Town	n or Loc	cation				1	10d. Inside City Limits
	Mary	ğ	Maryland Montgo	merv	Si1377	or (Spring					1 ☐ Yes 2 🖾 No
	7.28a	Director	10e. Street and Number	mer y	DITTY	CI L	10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
	h with		3227 Bel Pre Roa	d			2090	16			ed St	•
	n 72 hours after death with the Maryland "natural", or lieme 23a or 28a-f ehow salical Exbrainer must be notified at	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No-	14. Ra	ce - Americ	can Indian,
٥	or Ite		1 Never Married 2 Married	1 Yes 2 X	No		Yes, specify Cuba ☐ Yes 2 No		o Hican, etc.)		ck, White,	etc.
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7	within 72 ene. then "na	шp	Elementary/Secondary (0-12)	College (1-4or 5	(+)							
N	filed v 1 Hygie other 1	ပိ	17. Father's Name (First, Middle, Las.	3		Lega	al Secret		(Fi Adid-t- A	Lega		
/land	be d start	Be		/					ne (First, Middle, M			
	should nd Mer marke imatic	으	Leo W. Gannon 19a. Informant's Name/Relationship	Tuna Print)	105	Maille	Add (Ch		ine Ange. ral Route Number,			
Mar	ss 1 and 2 should of Health and Me Hem 27 is mark rother traumation		Martin J. Gannon									
a)	is 1 and 2 of Health a Item 27 Is other train		20a. Method of Disposition	/ Blother	20b. Place of	Dispos	ition (Name of	-	San Mar	20c. Location		
2	Pages nent of unt: If It		1 ☐ Burial 2 ☑ Cremation 3 [cemeter	y, crem	atory or other place	· 1				
saitimore,	artme ortan injury		4 ☐Donation 5 ☐ Other (Special Service Lice		Ft. Li		n Cremat	- 1				Maryland
ä	permit. Pages Department of Important: If It any injury or once.			1) _		Sin	ple Trib	ute Fune	ral and (Cremati	Lon Ce	enter
		-	23a. Part1. Enter the disease, or con shock, or yeart failure. List only	plications that caused	the death. Do n	not ente	r the mode of dvino	LIE FIKE	, Rockvi	LIE, Ma	тутаг	Approximate
	Dhusisian		shock, or beart failure. List only Immediate Cause (Final	one cause on each lir	10.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	EPTIC a consequence of		SHOCK					IDAY
	Examiner		1			,	0	010				Dan
		Je.	Sequentially list donditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	of):	R D	NI-OMI	W 1 K-1			171795
	od id ansit	Examiner	Cause (Disease or injury that initiated events	<u> </u>	(GI)	UL.	LITIC					- 2617
Ď.	exec en an rial-tr		resulting in death) Last	Due to (or as	a consequence o	of):						1)1445
09/99	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	edical		_ d								
	ing pl		IF FEMALE:									
õ	ath cer tendir or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		3 □	Ectopic pregnancy				te of delive	-
	he dea	Sici	1 ☐ Yes 2 No	4□Pregnant at 9□ Unknown			Other (specify)			Mo	onth	Day Year
י י	The law requires that the death ate has been signed by the etter page 2 should be detached for u	Physician/M	9 Unknown /									
ń	igne bed	र्व	Part II. Other significant conditions									e cause of death?
ecords,	requi	ted		RECTA					1 □ Ye	s 2□No	3 ☐ Prob	ably 4 SUnknown
n D	a law nasb e 2 sl	Completed by	HTN DEME	NTIA	SCH12	OP	HRENI	17	24a. Was an		Were auto	psy findings available appletion of cause of
	cate pag	် ပြ							perform	ned?	death?	2□ No
<u>a</u>	cian ertific ector,	Be	25. Was case referred to medical examiner?						th Check only one			
5	Physic this c	ို	1 Yes 2 No	Hospital: 1 Inpatie			3□ DOA Othe	1. 4 Nursing H	ome 5 Reside	nce 6 □Oth	er (Specify	<i>'</i>)
5	ling f	<u>ë</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		ime of ijury	28c. Injury Work	?	28d. Describe hor	w injury occur	red	
Nision	ttend death stor: the f	cat	2 Accident investigatio 3 Suicide 6 Could not b					′es 2 □ No				
2	after Direct in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At nome, far . (Specify)	m, stre	et, factory, office		28f. Location (Str City or Town,	eet and Numb , State)	er or Rura	l Route Number,
	spital ours neral filled		29a. Certifier 1 Certifying Pl	ysician: To the best of	f mu knowladaa	dooth		- data and alam		/ > - /		
	To the Hospital or Attending Physician: The law within 24 burus after death, within 24 burus after death. To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s	Medicai	(Check only 2 Medical Example)	niner: On the basis of and manner sta	examination and	t/or inve	estigation, in my op	inion, death occur	red at the time, da	te and place,	and due to	the cause(s)
	To th withir To th	M	29b. Signature and title of certifier	0	1		29c. License			d. Date signe		
			mue	roder	John	,1	n Do	0576	30	11-2	-5	2006
	3		30. Name and address of person who	completed cause of de						-		
			Anuradha Arun,					, Silver	Spring.	Marv1	and 20	0902
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature							
	Registra	ar	Ut.U - 1	2006	J. J.	Acat	W.					
ALIC	AH 17 Rev 1/20	0.1		-		-						

			For State	State of Marylan	d / Depa	artmen			tal Hygi	ene	402	62
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Linda Beth Hawkin: 4a. Facility Name (If not institution, give see	5			Town, or Location of De.	De	Date of Death Month	Day Year 2, 2006 4c. County of Dea	3. Time of 9:30	
	Funeral	C.	Northampton Manor 5. Social Security Number 216-64-0915			If Under Months		1. (/	Date of Birth Month, Day, 1		ck thplace (State o ountry) nington,	
		tor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder		y, Town or Lo	deric	k	- pa	Ly 0, 1.	yyy wasi	10d. Inside Cit	ity Limits
	ath with the	rai Directo	10e. Street and Number 1734 Dogwood Court	=		10f. Zip	21701		U	10g. Citizen of What Country? United States		
980	within 72 hours after death with the Maryland ene. then "netural", or itema 23e or 28a-f show he M. Jigal Exe. illier ust be motified at	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☼No If Yes, Give Year or Dates:	j	Was Deced f Yes, spec 1 ☐ Yes	dent of Hispanic Origin? cify Cuban, Mexican, Pue 2⊠No Specify:	Specify into Rical	Yes or No- n, etc.)	14. Race - American Indian Black, White, etc. Specify: White		
1215-0	be filed within 72 hours aft ital Hygiene. rd other than "natural", or event, the Madical Exerci	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	kind of wo DO NOT us	•	orking	16	6b. Kind of Business Financia	•	
yland 2	should be filed ind Mental Hygic marked other umatic event, II	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
Baltimore, Maryland 21215-0036	1 and 2 s Health ar tem 27 is		19a. Informant's Name/Relationship (Ty. David Horwitz / Bi 20a. Method of Disposition 1□Burial 2⊠Cremation 3□R	cother 20b. F	455 I	Darth sition (Name matory or o	ther place) Dec		711, PA	City or Town, State, 17313 Oc. Location - City or		
Baltim	permit. Pages Department of Importent: If it any injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Res	195	Name and Sthar	nd Address of Facility Ven Funeral atoctin Mtn	. Hw	vices, v. Free	derick. M	dy P.A.	<u>.d</u>
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. Use only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	cations that caused the deat e cause on each line. CANCER OF Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	BILIA uence of): E JAU	RY T	RACT	ac or res	piratory arres	st,	Approximate Interval Betv Onset and D	ween
68760,	ificate be executed g physician and as the burial-transit	cal	resulting in death) Last	Due to (or as a conseq	uence of):							
O. Box	law requires that the death certifica as been signed by the attending ph 2 should be datached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3□	Ectopic pr Other (sp			-	23d. Date of de Month	•	/ear
ords, P.	w requires that been signed b should be dat	þ	Part II. Other significant conditions con		ulting in the u	nderlying c	ause given in Part I.			cco use contribute t		leath? Inknown
of Vital Records,	The ate h page	Completed	DIABETES MELLI 25. Was case referred to medical	TUS				1	24a. Was an autopsy performe	ed? death?	utopsy findings a completion of ca s 2 No	available ause of
ion of Vi	ing Physici After this cer uneral direc	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I	ER/Outpatien 28b. Time of Injury	-	26. Place of D OA Other: 4 Nursing 8c. Injury at Work? 1 Yes 2 No	Home	5 🗌 Residen	ce 6 Other (Spe vinjury occurred	ocify)	
Division	Hospital or Attend 24 hours after death Funeral Director: , stely filled in by the f	il Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	y) 				City or Town,			ber,
v	To the Hos within 24 ho To the Fun completely	Medicai	(Crieck only 2 Medical Examination) 29b. Signature and title of certifier	eer: On the basis of examina and manner stated.	tion and/or in	vestigation,	, in my opinion, death oc	curred at	the time, date	e and place, and du	h. Day, Year))
1)		30. Name and address of person who co	Hague	700 M	ONTO	DO0540			112m3 - 10	- Co	
	Sta Registr		31. Date filed (Month Day, Year) 5 20	06 32. egistrar's Signa	iture	medi	<i>p</i>					-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Hilton 29, Gloria z. November 2006 8:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care- Potomac Potamac Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Months Pennsylvania Director 31, 1921 578-12-8422 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than may Injury or other traumaft event, the Medical Examiner must be notifiled at Director Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4849 Leland Street Funeral 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: \$ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Hame 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel C. Zeoli Sara L. Chappell ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia Lee Flynn/ Daughter 20a. Method of Disposition 4849 Leland Street, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State November 30, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant signed by the atter Id be detached for u 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 🗌 Yes been

Completed by Be 2 Certification:

has page 2 s

funeral director.

filled in by

Medical

this

within 24 hours after death To the Funeral Director:

or Attending Physician:

To the Hospital

Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an

Year

а М

1 ☐ Yes 2 No

25. Was case referred to medical examiner?	T
examiner:	- 1 1
1 ☐ Yes 2 🔀 No	Ľ
27. Manner of Death	
1 Natural 5 ☐ Pending	
1 ☑ Natural 5 ☐ Pending	

29a, Certifier

(Check only one)

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

autopsy 2X No

1∐ Yes

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

29c. License number H51280 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed bluse of death (Item 23a) (Type, Print)
Anushiravan Dadgar, M.D 9715 Medical Center Drive, #201, Rockville, MD 20850 cause of death (Item 23a) (Type, Print)

November 30, 2006

State Registrar

2006



			For State Registrar	State of M	larylan	-	artment of rtificate of				jiene eg. NG. ()	06	40264
É.	Physici	an	1. Decedent's Name (First, Middle			T 1			2	. Date of Dea Month	th Day	Year	3. Time of Death
	/Medic	_	Betty	К.		Jenkin				Decembe	1	2006	8;15 A M
	Examin	ier	4a. Facility Name (If not institution 14300 Jared	-			4b. City, Town,	aptown				nty of Death 11egar	
			5. Social Security Number			last birthday)	If Under 1 Yea	r If Under		. Date of Birth)		olace (State or Foreign ntry)
	Funeral Director		215-20-7393	1 ☐ M 2 🔀 F	83	Yrs.	Months Day	s Hours	Min.	(Month, Day	1923 Pennsylvania		
(A)	p.		Usual Residence of Decedent		140. 63								
	arylar ehow	<u>_</u>	10a. State 10b. County	7.7	10c. Cit	y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ecto		llegany			resaptor				l0g. Citizen o	of Minat Cou	71
	with t	Ö	10e. Street and Number 14300 Jared	Drive Ict	tr			502			-		nuy!
	eath	Funerai Director	11. Marital Status	12. Was Deceder		.S. 13.			igin? (Speci	fv Yes or No-		SA lace - Americ	can Indian,
'	r iten	Fun	1 Never Married 2 Marr	Armed Forces	? }No	1	Was Decedent of If Yes, specify Cu			can, etc.)	8	Black, White,	
93	al', o	by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates	:		1□Yes 2∏ N	o Specify:	:		Spec	cify: Wh:	ite
2-0	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f ehow event, the Medical Examinational termolination.	Completed	15. Deceden (Specify only highes			16a. Dece	dent's Usual Occ	upation e during mos	st of working		16b. Kind of	Business/In	dustry
21	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4o	5+)	life.	DO NOT use reti	red)					
2	e filed within al Hygiene. I other than 'vent, the Me		17. Father's Name (First, Middle,	(ast)		1	Homemake	7	ar's Nama /	First, Middle,		Home	
Maryland 21215-0036	ntal hed of	Be	Harry	Leroy	Ki	irchner	1	10. 10.0	Emma		arl		nith
2	should be and Menta marked umatic ev	ဥ	19a. Informant's Name/Relations				ng Address (Stre	et and Numb					
S	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Wanda L. Fish		er		-						MD 21502
	of Healitern other		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other p		Dat		20c. Location		
Baltimore,	permit. Pages of Department of the importent: If ite any injury or of once.		1 ☐ Burial 2 🎇 Cremation 4 ☐ Donation 5 ☐ Other (S		θ		nd Crema		2/07/	2006	Cumbe	rland	MD
alti	permit. Departmimporte		21. Signatur, of Huneral Service	Licensee							ily Fu	neral	Home, P.A.
m	9 9 5 5 8		Kolet C	. Al	-1		404 Dec	atur S	treet	, Cumbe	erland	, MD	21502
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	ine.		ter the mode of d	-					Approximate Interval Between Onset and Death
18	/Medical Examiner		resulting in death)	Due to (or a									
	- Administra	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a conseq	wanca of							
	led Isit	Examine	cause. Enter Underlying Cause (Disease or injury	C Due to (or a	s a conseq	derice or,							
•	and al-tra	xar	that initiated events resulting in death) Last	CDue to (or a	s a conseq	uence of):							
200	ate be executed hysician and the burial-transit	calE											
68760,	ficate g phy as the												
Вох	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic pregnar	101			23d. [Date of delive	егу
	death	sicia	in the past 12 months? 1 □ Yes 2 ※No	4☐Pregnant 9☐Unknown			Other (specify)	icy			,	Month	Day Year
P.0	that the de ned by the a detached t	h,	9 🗌 Unknown	9 Olikilowii									
Ś	The law requires that the death certificate be executed sie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant condition DECYPI			ulting in the u	Inderlying cause (given in Part	I.	23e. Did to			he cause of death?
S	has be	Completed								24a. Was a		b. Were auto	opsy findings available impletion of cause of
<u>m</u>	The faste has page	Con								perfor 1 ☐ Yes	med? 2)(I) No	death?	2 No
of Vital Record	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medica examiner?						e of Death (Check only or	ne)		
5	Physicia this cert al direct	2	1 ☐ Yes 2 No 27. Manner of D ath	Hospital: 1 Inpa		ER/Outpatie	III JOON			5 X Resid			fy)
n n		io	1 Natural 5 ☐ Pendir		ay Year)	28b. Time o Injury	W	lury at fork? □ Yes 2 □		d. Describe h	ow injusy occ	urred	
isi	in a in	ical	2/□ Accident Investi 3 □ Suicide 6 □ Could	not be 290 Place of I	niury - At h	ome farm st	reet, factory, offic			f. Location (S	treet and Nu	mber or Rur	al Route Number,
Division	after Dire	Certification:	4 Homicide determ	building,	etc. (Specif	(y)	reet, radiory, onic	•		City or Tow	n, State)		
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the	edical C	29a. Certifier 1 💢 Certifyir (Check only one)	g Physician: To the bes Examiner: On the basis and manner:	of examina	owledge, deat ation and/or in	h occurred at the	time, date ar opinion, dea	nd place, an ath occurred	d due to the c at the time, d	ause(s) and late and plac	manner as s e, and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. Lice	nse number		2	9d. Date sign	ned (Month,	Day, Year)
	->-0		> th	1			DC	03481	2		Decem	nber 6	, 2006
	2		30. Name and across of person	who completed cause of	death (Iten	n 23a) (Type,	Print)						
	5,		Z ugene N	allin, M.D.	, 90	9B Set	on Drive	, Cuml	berlan	d, MD	21502	2	
	Sta	ate	31. Date filed (Month, Day, Year)	32. R	trar's Signa	ature	4						
4	Regist	rar	DEC 0	7 2006	ELS.	H. A	0243						

		Amend #12 Per Inf (362) 1 - For Amend #27 Per 1 Registrar	Type or Print in I 12/29/06 H State of Marylan Try 6862 12/18/08	in thoch	artinent of i	neallii ailu ivi	I Copies lental Hy	giene	ible.
		Registrar 1. Decedent's Name (First, Middle, Last		Cei	rtificate of	Death	2. Date of De	neg. No.L.	UD 4UZD
Physici	an		'				Month	Day	Year 2006 4:45 A M
/Medi Examir		Karl M. Korn 4a. Facility Name (If not institution, give	street and number)		4b. City. Town.	or Location of Death	Novemb	er 20	
	lei	Heritage Harbour He	ealth Center	last high days	Annapol	is.	Anne Ar		Arundel
Funeral Director			M 2□F 92	Yrs.	Months Days		09/25/	ay, Year)	9. Birthplace (State or Foreig Country) Washington, D.(
yland		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
Sa-fet	ctor	Maryland Anne Aru	ndel Anna	apolis					1 □ Yes 2 🖔 N
or 2	<u>=</u>	10e. Street and Number	011		10f. Zip Code				What Country?
8 23g	rai	803 Coxswain Way, A		C 12	21401	Historia Osisia 2 (San			States
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Department: If term 27 le marked other then "naturel", or items 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Evenin U Armed Forces? 1 (24%) 2 (21) No If Yes, Give Year or Dates 1940-4		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Special	ce - American Indian, ick, White, etc. ^{(y:} White
ture sture	pa	15. Decedent's Edu		16a. Dece	dent's Usual Occu	pation		16b. Kind of E	Business/Industry
filed within 72 Hygiene. rther then "nu	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retire	during most of working	ng	I.R.S.	,
Hygi Hygi Ther nt,	ပို	17. Father's Name (First, Middle, Last)	<u> </u>	nuule	.01	18. Mother's Name	(First, Middle		me)
id be ental ked c	To Be	Michael Korn				Katherin	ne Blad	t	
should ind Men marke umatic	-	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailir	ng Address (Stree	t and Number or Rura	l Route Numb	er, City or Town	, State, Zip Code)
alth a		Mary Louise Troutma	n/Sister	803 0	Coxswain	Way, Apt.2	209 Ann	apolis.	MD 21401
Pages 1 a ent of He nt: If Item ry or oth		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. F	Place of Dispo	sition (Name of matory or other pla	ice)	ate	20c. Location	- City or Town, State nd, Maryland
permit. Departm Importa eny inju		21. Signature 31 Foregray Service Licens	98			ess of FacilityGeo1	ge P.	Kalas F	uneral Home r, MD 21037
death certificate be executed e attending physicien and for use as the burial-transit	licai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Caecha		ny/bm	la e			Interval Between Onset and Death
that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnanc	у			ate of delivery onth Day Year
w requires that s been signed b should be deta	y P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use con	tribute to the cause of death?
equire en si ould t	ted	Jellia					1 🗆 '	Yes 2 □ No	3 Probably Unknown
The law requires that the ate has been signed by th page 2 should be detache	Completed by	Aspiration	n pluc	uia.	-		24a. Was autor perfo	rmed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Physician: r this certifica ral director, I	Bec	25. Was case referred to medical examiner?	****			26. Place of Death			
hysic hysic l dire	P	1 Yes 2 No	lospital: 1 Inpatient 2 I	EP/Outpatier	t 3□ DOA Ot	her:	ne 5 ☐ Resi	dence 6 □Oth	ner (Specify)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director Atter this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	nyat nk?]Yes 2 □No	28d. Describe I	how injury occur	red
s after de se se se se se se se se se se se se se	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office	2	28f. Location (a City or To		ber or Rural Route Number,
To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my knower: On the basis of examina and manner stated.	wiedge, deati	occurred at the ti vestigation, in my	me, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and m date and place,	anner as stated, and due to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier			29c. Licen.	se number		29d. Date signe	ed (Month, Day, Year)
		30. Name and address of person who co	empleted cause of death (Item	п 23а) (Туре,	Print)	mound	$\leq m$	7 214	17/
Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's signa	ature	- 1001 [mayor	νm		101

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** DWARD KALIN 9:13 26 ,2006 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL LENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months 123-28-2353 Director Nov.25, 1935 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 6604 Charles Drive 21771 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) be filed within 7 tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) engineer Federal government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othe any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Kalin Frances Eileen O'Herin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21791 19a. Informant's Name/Relationship (Type. Print) James D. Kalin/ son P.O. Box 259, 23 W. Broadway Union Bridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery | 12/4/2006 Minoa, New York 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses atharine 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cholangitis Sequentially list conditions, if any collections in immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No or Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes SANo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division the Hospital or Attending 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) NOVEMBER 26, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE STREET, BALTIMORE, MARYLAND 21201 22 SOUTH MARC BRAZIE, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 3 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1035 A M Faber Charles Knepper 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 76 162-22-7187 15,1930 Pennsylvania Sept. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Me Acal Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** Franklin Greencastle PA10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17225 U.S.A. 11357 Cool Hollow Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. MYes 2∏ No Yes, Give 'ear or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Gourley Charles Faber Knepper ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pamela Weaver Knepper (Wife) 11357 Cool Hollow Rd. Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 13, 2006 Smithsburg, Maryland 21, Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 PAVIS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ryens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The lay requires that the death certificate be executed burial-transit Completed by Physician/Medical Exami and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Other (specify) 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 1 Yos 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performe 2 No or Attending Physicians Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide within 24 hours a Medical 29a. Certifier 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. (Check of I) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 0. Name d address of person

Registrar

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Redistrar's Signature

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31. Date filed (Month,

State of Maryland / Department of Health and Mental Hygiene, For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month November 27 Lindsay Doris Jeannette 2006 5:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Nursing & Rehab. Ctr. Winfield Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 7 F Yrs. Director 217-16-2265 84 1922 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?? Is marked other than "naturel", or Itema 23a or 28a-f ehov treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1442 Buckhorn Rd. 21784 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) manager state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maurice William Bankerd Effie Jeannette Zile 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Gertrude Robertson - sister 122 N. Main St. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its any njury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State Pipe Creek Cemetery 11/29/2006 nr. Linwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 3 Probably 4 Dinknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No certificete hes tirector, page 2 s autopsy performed? 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☑ No After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification; 28d. Describe how injury occurred 1 SNatural 5 Pending investigation 1 Yes 2 No neral Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours after To the Funeral Dira Hospital 29a. Certifier 1 Decritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 1000 LIBURTY RD ELDWIBURG ND 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) TURNES. ATRICK SUITE 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Esther Elizabeth Lehr December 6, 2006 6:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Co. Nursing & Rehab Center Cumberland
If Under 1 Year | If Under 24 Hrs. Allegany

9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 🂢 F 216-14-1271 90 Director 06/30/1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at Director Allegany 1 Yes 2 No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iten important: or other traumatic event, the Medical Examinal anay injury or other traumatic event, the Medical Examinal since. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: δ 3 ♥ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis DeSales Smith Marv Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol Ann Moritz / daughter P.O. Box 1033, Ridgeley, WV26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 12/7/2006 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD ale Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIE OBSTRUCTIVE LUNG DISSASS TRI /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 1 TYes 2 No Division of Vital : After this certification in the section of the se Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 10 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 1 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No М investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel the l 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano J. Barrera, M.D., 500 Memorial Avenue, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State DEC 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar #16a, perADM, 12/1/06, DFS, MCO

Georgiest's Name (First Middle 1 and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20, 2006 4:28 AM M Inez Long November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Numberunk 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 418-34-1409 79 Director Jan 27m 1927 ALabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any luny or other traumatic event, the Medical Examiner must be notifiled at once. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2√ No MDMontgomery Germantown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13114 Briarcliff Terrace 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify black Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) crossing quard 12th corssing guard <u>education</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Eva Wilburn John Wilsher ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13114 Briarcliff Terrace Germantown, MD Katie Ferguson/daughter 20874 20a. Method of Disposition
1 □ Burial 2 □ Peremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 ☐Removal from State in state Riverdale Pk. Crem. Riverdale, MD 4 □ Donation 5 ₩ Othe 11/30/06 21. Signature of Suneral Shri Bard 555 W. Baltimere 21201246 N.Washington St. S Wade state matemy Board //Director Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) **Physician** Due to (or as a cons Juence of): /Medical Examiner 0STridun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): and burial-tran Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page performe this certificate 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 3 No 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MY 11/20/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Nimesh S.

31. Date filed (Month Day, Y

Shah,

Year)

M.D.

32. Registrar's Signature

9901 Medical Center Dr.,

Rockville,MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Susan Maggio-Sch		Z - For State	S	ate o	of Maryla		epartment o C <i>ertificate o</i>		d Mental H	ygiene				
Dhysisian	F	Registrar 1. Decedent's Name	First Midd	le Last)	Cucon			Death		2. Date of Dea	Reg No.	200	T3 Time of Death	
Physician Medical Examine		-Susan	Hele		Maggie					Month Decembe		Year 6	0845 hrs	
		4a Facility Name (if 814 Ramshe		-	street and nu	imber)		4b. City, Town, or Cockeysville		_		County of Deat Itimore Co		
Funeral		5. Social Security N	umber	6. Sex	(7. Age (In y	rs. last birthday)	If Under 1 Year		8 Date of B	irth(MM/DI		rthplace (State or	
Director		220-52-4	738	1	M 2XF		49 Yr	Months Days	Hours Min.	Apr.	13,	1957 Co	puntry) MD.	
xù e		Usual Residence of 10a. State	Decedent 10b. County			10c.	City, Town or Loca	tion					10d Inside City Limits	
* .		MD	Balt:	mor	·e		Cock	eysville					1 Yes 2 No	
the Marylanc s or 28a-f sh iffed at onc	3	10e. Street and Nur						10f. Zip Code			10g. Citize	n of What Cou	intry?	
123a or notified	- L	814 Ra	mshead	Ci				2103			USA			
or death with the Maryland or items 33a or 28a-f show must be notified at once.	5 I	 Marital Status Never Marrie 	ed 2 XM	arried	12. Was Dec	orces?	If `	as Decedent of His es, specify Cuban			0- 14	White, etc.	rican Indian, Black,	
ral", or		3 Widowed	4 Di	orced	1 Yes If Yes, Give Yea or Dates:	2 X N	1	Yes 2 X No	specify:	Specify: White			<i>h</i> ite	
hours Framing		15. Decedent's Ed Elementary/Seco			y highest grad College (1		d) 16a. Decede during n	nt's Usual Occupat nost of working life.			16b. Kin	d of Business/	Industry	
5-0036 ed within 72 hour lygiene other than "natu the Medical Exar		Elementary/Seco	ndary (0-12)		College (·	F	lomemaker		Own home				
215-0036 be filed within 7 trail Hygiene ked other than ent, the Medics		17. Father's Name (1	T.	18.Mother's Name					
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiand health and Mental Hygia other than "matural", or items 23a or 28a-fahr itranmatic event, the Medical Examiner must be notified at once To Be Compilered by Eumeral Director		William 19a. Informant's Na					19b Mailir	a Address (Stree		rances Matakaitis or Rural Route Number, City or Town, State, Zip Code)				
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		1	State of Maryland / Department of He State of Maryland / Department of He Certificate of Department of Department of He		tal Hygien	/11115	40272				
#2	Physicia	an	1. Decedent's Name (First, Middle, Last) Wayne Roger Marville	2. [Date of Death Month Den Da	oth xory	3. Time of Death				
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo			c. County of Death	/				
			Washington County Hospital Hagers 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1		Date of Birth	Washing	gton place (State or Foreign				
	Funeral Director			Hours Min. ('Month, Day, Year	943	ntry) Arkansas				
	TO		Usual Residence of Decedent		0, 1		10d. Inside City Limits				
	arylar show d at	<u>-</u>	10a. State 10b. County 10c. City, Town or Location PA Franklin Antrim Township)			1 ☐ Yes 2 X No				
	the M	Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Cou	ntry?				
	3a or	Ö	4456 Statler Road 172	225		USA					
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Natl guard 1 □ Yes 2 ☒ No Year or Dates:	panic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Ameri Black, White Specify:					
5-0036	72 hou natura lical E	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired)	ion ring most of working	16b. I	Kind of Business/Ir	ndustry				
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lary			19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street an								
	1 and Health Pm 27 ther tr		Debbie L. Marville wife 4456 Statler 20a. Method of Disposition 20b. Place of Disposition (Name of	Date		PA 1/ZZ					
nor	Pages nent of I int: If its iry or o		1 \$\bar{\text{Burial 2 \subseteq}}\$ Ceremation 3 \subseteq Removal from State 4 \$\subseteq\$ Donation 5 \$\subseteq\$ Other (Specify) Spring Hill Cemeter.	i	2006 F	aston Mi)				
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ion	Attending Physician: r death. ector: After this certific by the funeral director,	atior	2 Accident investigation M 1 Y	es 2 □ No							
Divis	= <u>5</u> # 6	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Street a City or Town, Sta	and Number or Ru ite)	ral Route Number,				
	the Hospital hin 24 hours a the Funeral upletely filled	ledical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time one one) 2 Medical Examiner: On the basis of examination and/or investigation, in my open and manner stated.								
	Vithi Vott	Z	29b. Signature and title of certifier 29c. License			ate signed (Month					
			Muchaef & Miland MD	11667		12.8					
/	27		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael McConnack (Illo Melical 31. Date filed (Month, Day, Year) DEC 18 2006 32. Redistrar's Signature	Comos R	N. Itas	scrotour	MP.				
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of Vital Rec ling Physician: The L After this certificate b funeral director, page	မ	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		Time of Injury 28c.	Injury at Work?		ow injury occurred	Striet. Scenie
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Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Exam	ner:On the basis of examination manner stated.	ation and/or	investigation, in my opi	nion, death occur	red at the time, date a	nd place, and due	to the cause(s)
F 3 F 8	₩.	29b. Signature and title of certifier	c la			.C.M.E.		29d. Date signed December 10	(Month, Day, Year)
		MOMUNTE V 30. Name and a dress of person w	me Shill	h (Item 23a)					· · · · · · · · · · · · · · · · · · ·
			Assistant Medical Ex		111 Penn Street	, Baltimore, N	/ID 21201		
	tate	DEC 4 6	32. Registrar's	Signature	front s				_
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06-09385 George Nutwell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-fish tranmatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marri	ied 12. Was Decedent Armed Forces?	Ever in U.S	If Ye	es, specify Cuba	an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)		/hite, etc.	can Indian, Black,
irs after ural", c	<u>a</u>	3 Widowed 4 Divorce 15 Decedent's Education (Specify	ced If Yes, Give Year or Dates: y only highest grade com	pleted)		Yes 2 X N		kind of work done	Speci.	.,.	white ndustry
5-0036 led within 72 hours after tygiene other than "natural",	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	+)		ost of working life		,		regate	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	O	12 17 Father's Name (First, Middle, La	ast)		sem e	mployed	18.Mother	's Name (First, Middl	e, Maiden Surna	ime)	-
2121 uld be fi Mental marked	To Be	George Lee 19a. Informant's Name/Relationship	Nutwell, Sr (Type, Print)	•	19b. Mailing	Address (Stre		herine nber or Rural Route N	Sherbe Slumber, City or 1		, Zıp Code)
MD nd 2 sho alth and m 27 is anmati		Louise C. Nutwel	l, wife	l aob n		Muddy C		Rd., West			20778 Town, State
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other trinjnry or other transmatic event, the Med		1 Burial 2 X Cremation	/	ite c	rematory or oth	er place)	•	12/14/200		•	
Baltin permit P. Departmet Importan injary or	-	4 Donation 5 Other Spec 21 Signature of Funeral Service In	censee					Rausch F			
ய கத்தத் Physician		23a. Part I Enter the disease, or co			832 Do not enter th	5 Mt . H e mode of dying	larmon g, such as c	y Lane, O ardiac or respiratory	wings, Narrest, shock, or		0736 Approximate Interval
/Medical Examiner		failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	a <u>Cirhosis of</u> Due to (or as a conse								Between Onset and Death
		Sequentially list conditions,	b								
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intrated	Due to (or as a conse								
cuted nd transit	II Exa	events resulting in death) Last	Due to (or as a conse	equence of):				· · · · · · · · · · · · · · · · · · ·		
60, ate be exe ohysician a	Medical	X UNPENDED				2863, 1/1	6/07 <u>T</u>	[I as i a i		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/M	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant at		2 Fet	al death 3 ner (Specify)	Ectopio	c pregnancy	Month	e of delivery h D	y Day Year
.O. Bc that the des ned by the s detached fo		Part II. Other significant condition	9Onknown	but not re	sulting in the u	nderlying cause	given in Pa	art I. 23e. Di	d tobacco use co	ontribute to	the cause of death?
s, P.O. uires that the n signed by I de detache	ed by								Yes 2 ✓ No		
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been is led in by the funeral director. page 2 should be a by the funeral director.	ompleted				·				topsy rformed?		topsy findings available completion of cause of
Vital Rec ysician: The his certificate director. page	Be C	25. Was case referred to medical examiner?	Hospital Inpatie	nt 2 🗸	ER/Outpatient		Other ₄	(Check only one) Nursing Home 5	Residence	6 Other	
fing Physic After this	n: To	1 Yes 2 No 27. Manner of Death 1 Natural	28a. Date of Inju (Month, Day,Y		28b Time of Ir	njury 28c. Inj	ury at Work	? 28d Descril	be how injury occ		
ision Attend r death. rector: by the f	icatic	2 Accident Investig	gation 28e Place of Inc	urv - At ho	me, farm, stree		Yes 2 building et		n (Street and Nu	ımber or Ru	ral Route Number, City
Divi	Certification:	3 Suicide 6 Could r 4 Homicide determ	not be						n, State)		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my iner:On the basis of exar	/ knowledg nination ar	ge, death occur nd/or investigati	red at the time, on, in my opinio	date and pla on, death oc	ace, and due to the concurred at the time, do	ause(s) and man ate and place, ar	iner as state nd due to the	ed. e cause(s)
To wit To con	Med	29b Signature and title of certifier	and manner stated	1			nse number				nth, Day, Year)
		30. Nalle an in ddress of pirson w					.M.E.		Decemb	er 10, 20	JU6
	ate	31. Date filed (Month, Day Year)	ssistant Medical Ex			n Street, Ba	Itimore, I	MD 21201			
St Regist		31. Date filed (Month, Day, Year) DEC 12	2006 Deser	16.1 1	0. Gp	Will					

1 - State Registrar Certificate of Death	Reg. No.						
1. Decedent's Name (First, Middle, Last) Physician Nellie Mildred Owens	2. Date of Death Month December 03, 2006 3. Time of Death 04:32 P	ı					
/Wedical							
Frostburg Village Nursing Care Center Frostburg Village Nursing Care Center Frostburg Village Nursing Care Center	Allegany						
Funeral Director 217-10-4262 6. Sex 1 M 2 F 95 Yrs. 6. Social Security Number 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 21-Nov-1911 Maryland	7					
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits						
Maryland Allegany Frostburg 10a. State 10b. County Frostburg 10a. State 10b. County Frostburg 10b. County Frostburg 10c. City, Town or Location Maryland Allegany Frostburg 10c. City, Town or Location Maryland Allegany Frostburg 10f. Zip Code 21532- 11. Marital Status 12 Was Decedent Ever in U.S. Amed Forces? 12 Was pecify Cuban, Mexican, Puerto 14 Yes, Give 14 Yes, Specify Cuban, Mexican, Puerto 14 Yes, City only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) 17 Father's Name (First, Middle, Last) 18. Mother's Name	1 Ş Yes 2□No						
Maryland Allegany Frostburg 10e. Street and Number 510 Grandview Drive	10g. Citizen of What Country?						
21532-	U.S.A.						
21332- 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Never Married 3 Neve	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.						
1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: Year or Dates:							
Specify: Specify:	Specify: White						
The second state of the se	king						
College (1-4or 5+) 12 Elementary/Secondary (0-12) 4 College (1-4or 5+) administrative secretary	fibers manufacturer						
To a figure 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	ne (First, Middle, Maiden Sumame)						
Charles Hudson Owens, Sr. Nellie Ma	arrow Campbell						
0 "2 " 2	ral Route Number, City or Town, State, Zip Code) nomasville N. Carolina 27360						
20a Method of Disposition 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	_					
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 F	04-Dec-06 Cumberland Maryland						
21. Signature of Funeral Service Licensee 22. Name and Address of Facility	- 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-					
Durst Funeral Home, 57 F	Frost Ave., Frostburg, MD 21532						
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	or respiratory arrest, Approximate Interval Between Onset and Death	4					
/Medical resulting in death) Due to (or as a consequence of):							
Sequentially list conditions, and any, leading to infinediate cause. Enter Underlying Cause (Disease or injury		\neg					
Tarry, leading to finitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.							
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
dical line be							
SO TO THE FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves. and No. are the pregnant of the pregnant of the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	201 201 415						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Vec a Vec	23d. Date of delivery Month Day Year						
1 Yes 2 No 9 Unknown 9 Unknown							
SO TO THE TENNION OF THE PART II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part I. Condition of the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part II. Condition of the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause ewen in Part II.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown						
Dankinson Deser	24a. Was an 24b. Were autopsy findings available	3					
Om le har age 2	autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No						
TO S US S US S Case referred to medical 25. Place of Deat examiner?	th (Check only one)						
\$ w = V I Lifes 2 Life I Linpatient 2 Lien/Outpatient 3 Libon 4 Linux single in	ome 5 Residence 6 Other (Specify)						
27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work? O Death Standard Superstination O Death Standard Superstination O Death Standard Superstination O Death Standard Superstination O Death Standard Superstination O Death Standard Superstination O Death Standard Superstination	28d. Describe how injury occurred						
O D C C C C C C C C C C C C C C C C C C	28t. Location (Street and Number or Rural Route Number,	_					
To see the control of	City or Town, State)						
	, and due to the cause(s) and manner as stated.	-					
29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. 29b. Signature and title of certifier or 29b. Signature and title of certifier or 29c. License number	rred at the time, date and place, and due to the cause(s)						
and manner stated. 29c. License number	29d. Date signed (Month, Day, Year)						
	3x Necessalie 4 200	16					
3. Changer 2256	Jo . Learning.						
30. Name and address of person who completed base of death (Item 23a) (Type, Print) SATURN INA CHANGIND & Broodway Front 31. Date filed (Month, Day, Year) 32. Revistrar's Signature	Long Mary land 215-32	_					

State of Maryland / Department of Health and Mental Hygier@ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 11 30´ 2006 6:56 PM Martha Faraklas Polanskas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Hospital Center Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2# F Yrs Director 147-34-7603 05/31/1926 Texas Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or iteme 23s or 28s-f show or other treumstic event, the Misoisal Examiner must be notified at 1 ☐ Yes 2 ☐ No Hampstead MD Carroll Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2115 Moonlight Drive 21074 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Item eny injury or other treumatic event, the Madical Examinations. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ₽ No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva Saldivar Thomas Faraklas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth E. Rostek Daughter 2115 Moonlight Dr. Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Carroll Cremation 12/04/2006 Hampstead, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee 934 South Main Street Hampstead, MD M00723 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final 2 Mouths **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1☐ Yes 2☐No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy 1 Yes 2[25. Was case referred to medical examiner? Be 26. Place of Death Check only or Hospital: Other: 4 Nursing Home Director: After this c in by the funeral dire 2 1 🗌 Yes Nα 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manne f Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation atural Accident death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 \ Homicide filled within 24 hours a To the Funerel C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely le of certifier 29b. Signature and ti 29d. Date signed (Month, Day, Year) WIL 30. Name and ha completed cause of death (Item 23a) (Type, Print) 8 State post Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of N	Maryland		artment rtificate			nd M	ental Hyg	iene	0.6	40277		
1 73	Physic	an	Decedent's Name (First, Middle, I								2. Date of Deat Month		Year	3. Time of Death		
	/Medi		William		Richard			age			Decembe	,	2006	6:20 A M		
	Examir	ner	4a. Facility Name (If not institution, g Devlin Manor I	lealth Car	e Cente		C	umbe	Location of erland	i		Ac. County of Death Allegany				
de	Funeral Director		5. Social Security Number 220–16–7100 Usual Residence of Decedent	Sex 1 ☑ M 2 ☐ F	Age (In yrs. las	st birthday) Yrs.	If Under 1 Months	Days	If Under 2	Min.	8. Date of Birth (Month, Day, 03/17/1					
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d, Inside City Limits		
	Many P-f eh	tor	MD Alleg	any		Cumb	erlan	d						1 X Yes 2 □ No		
	or 28,	Director	10e. Street and Number				10f. Zip (Code			10	Og. Citizen o	of What Cou	ntry?		
	ath w		701 E. Fourt	h Street				2150	2			U	SA			
Maryland 21215-0036	72 hours after death with the Maryland naturel', or items 23a or 28a-1 ehow iksal Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 [X] Yes 2 [If Yes, Give Year or Date:	s? ∃No UUJTT	1	Was Decede f Yes, specif		spanic Origi n, Mexican, Specify:	in? (Spec Puerto F	offy Yes or No- lican, etc.)		etc.			
5-0	72 hc	Completed	15. Decedent's (Specify only highest of	Education rade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupa	tion uring most o	of workin	a 1	16b. Kind of				
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ary	2 5 E E	-	19a. Informant's Name/Relationship					Street a						.,		
	and 2 salth a n 27 Ju		Mayola P. Banks	/ sister							land, M					
ore	of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	Removal from Stat	20b. Plac	ce of Dispo	sition (Name	e of		Da				own, State		
Ë	artment curtant: curtant: injury c		4 Donation 5 Other (Spec		Cumb						72006			,		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	1-1		1	104 De	cati	ır Str	eet,	Cumber	land,				
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus y one cause on each	ed the death. line.	Do not ente	er the mode	of dying	, such as ca	ardiac or	respiratory arre	st,		What Country? A Ce - American Indian, ck, White, etc. by: Black dusiness/industry ing Home Davis State, Zip Code) d 21502 City or Town, State Pland, MD Deral Home, P.A. MD 21502 Approximate Interval Between Onset and Death ADDEN Approximate Interval Between Onset and Death Approxima		
ķ.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. AC	LIETE	NI	140C	AR	DIA	LZ	NFA	RCTI	1001	Supple N		
	/Medical Examiner	Ç.	resulting in dealiny	Due to (or a	as a consequer	nce of):	Δ	07	00				0, 0	V		
(2) 9	* * * * * * * * * * * * * * * * * * *	-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequer	127 nce of):	-/1	1<1	ER	1 4)15151	425		12AKS		
	cate be executed by sician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events											,		
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	death certificate be executed e attending physicien and ad for use as the burial-transit	Physician/Medical	IF FEMALE:	00 4				-								
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal de	eath 3 🗆	Ectopic preg							*		
P.O.	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of deat	m 5∟	Other (spec	crry)						,		
	The law requires that the ite has been signed by thoage 2 should be detached.	by Ph	Part II. Dther significant conditions	contributing to death	but not resulting	ng in the un	derlying cau	ise giver	in Part I.		23e. Did toba	acco use cor	ntribute to th	ne cause of death?		
rds	w require been sig should b	ed b	DIABETE	SME	LLIT	15					1 🗆 Yes	2 □ No	3 Frob	ably 4 Unknown		
Division of Vital Records,	aw requisits been 2 should	Completed	PERIPHIERA	L. 1/AS	CULF	TR 1	015%	3A	88		24a. Was an	24b	. Were autor	psy findings available		
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ita	Attending Physician: r death. sctor: After this certifics by the funeral director.	Bec	25. Was case referred to medical examiner?						26. Place of	f Death /	Check only one		1 1 1 1 1 1 1	25140		
5	Physic this o	P.	1 Yes 2 No	Hospital: 1 🗌 Inpai			3□ DOA	Other	4 💢 Nursı	ing Home	e 5 ☐ Residen	ce 6 □Ot	ther (Specify	1)		
n C	Jing F	Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	jury Year) 28	Bb. Time of Injury		Work?	at	28	d. Describe how	injury occu	rred			
<u>is</u>	death ctor: / the f	licat	2 Accident Investigation 3 Suicide 6 Could not	DB Glass of th	niugy - At home	o farm stra	M .		es 2 No		of Lagation (Ctua					
<u>S</u>	after Direct	ertii	4 Homicide determine	building,	etc. (Specify)	o, iaiiii, siie	et, factory, t	onice		20	f. Location (Stre City or Town,	State)	iber or Hurai	I Houle Number,		
	spita hours meral		29a. Certifier 1 🖔 Certifying P	hysicien: To the bes	t of my knowle	odge, death	occurred at	the time	, date and p	place, an	d due to the cau	ise(s) and m	nanner as st	ated		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	miner: On the basis and manner s	or examination	and/or inv	estigation, in	n my opii	nion, death	occurred	at the time, dat	e and place	, and due to	the cause(s)		
	Tot Tot com	Σ	29b. Signature and title of certifier	10	1		29c. l	License			290		ed (Month, L			
	5		1	n K	an	m		D00	54004			Dece	nber 4	1, 2006		
<	'x'		30. Name and address of person who													
			Shiv C. Kha 31. Date filed (Month, Day, Year)		1221 Ar's Signature		onal 1	High	way,	LaVa	le, MD	21502	2			
	Sta Registra	_	DEC 0		Cilva .		Local	5								

Esther PREACTOR

7. Age (In yrs. last birthday)

73

Certificate of Death

4b. City. Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

578-42-2956

Maryland

10a. State

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10b. County

Montgomery

Hebrew Home of Greater Washington

1 M 2 TF

Physician

/Medical

Examiner

Funeral

Director

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2. Date of Death 3. Time of Death Month

5:20 A

November 29, 2006 4c. County of Death

Montgomery

Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)

Days

1933 Washington, 10c. City. Town or Location 10d. Inside City Limits

1 ☐ Yes 2 X No Germantown

10g. Citizen of What Country? 10f, Zip Code

> United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Specify: white

16h Kind of Business/Industry

Doctor's Office

18. Mother's Name (First, Middle, Maiden Sumame)

Fannie Brill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13104 Country Ridge Drive, Germantown, MD

20c. Location - City or Town, State 11/30/06

Torchinsky Hebrew Funeral Home

20012

Approximate Interval Between Onset and Death

23d. Date of delivery Month

Day

Olney, MD

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 Tyes

Year

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

01808

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MONTROSE RD INESH - MD 6121

31. Date filed (Month 32. gistrar's Signature State Registrar

(Check only

29b. Signature and title of certifie

DHMH 17 Rev 1/2001

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			T = For State Registrar	State of	Maryland		artment of I				giene Reg. NZ ()	06	40279
300	Physici /Medic	_	1. Decedent's Name (First, Middle Frankie J. Ra	tliff						2. Date of Dea Month December	Day 1, 2	Year 006	3. Time of Death 08:45 AM
40	Examin Funeral	er ं.	4a. Facility Name (If not institution Laurelwood Nurs 5. Social Security Number	ing and Re		st birthday)	4b. City, Town, of E1kt If Under 1 Year Months Days	on If Under		8. Date of Birth (Month, Day	Ce	cil 9. Birth	place (State or Foreign
O _A e	Director		228-42-2861 Usual Residence of Decedent	10 M 29AF	76	Yrs.				Feb. 3	, 1930		rginia
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene, item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Exemples must be notified at	Director	10a. State 10b. County Maryland Cec 10e. Street and Number	i 1		Town or Lo	10f. Zip Code				10g. Citizen	of What Cou	10d. Inside City Limits 1 ☐ Yes 2 🛣 No Intry?
	h with	a D	335 Appleton Ro	ad			2192	.1			Unite	d Sta	tes
36	urs after deal	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Deced	2 <u>X</u> No	1	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No			cify Yes or No- Rican, etc.)	14. R 8	Race - Amer Black, White cify:	
21215-0036	e filed within 72 ho al Hygiene. other then "natur vent, the Medical I	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1 2	's Education it grade completed) College (1-	4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during mos	st of workin	ng	16b. Kind of		ndustry
Q	Hygiv other ent.		17. Father's Name (First, Middle,	Last)	1	non	lellakei	18. Mothe	er's Name	(First, Middle,			
ylan	should be nd Mental marked c	To Be	Henry Smith					M	ary I	Brown			
Maryland	nd 2 shoul Ith and Me 27 is mark treumati		19a. Informant's Name/Relations! Pat Reynolds /				ng Address (<i>Str</i> ee) Appleton						
Baltimore,	Pages 1 and intention of Health of Health of: If item 27 ry or other tr		20a. Method of Disposition 15 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from S	late	ace of Dispo metery, crea	esition (Name of matory or other pla	ice)	Decem	mber	20c. Locatio	n - City or T	own, State Maryland
Balti	permit. Pages 'Department of H Importent: If ite any njury or of		21. Signature of Funeral Service	Light Be			2. Name and Addre			rouch F	uneral	Home	ryland 21901
	Physician //Medical Examiner physician and physician ithe privateransit	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to annualist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	used the death. ch line. I solve the second of the second	ence of):	er the mode of dyi	ng, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death ILN KNOWN
P.O. Box 68760,	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal on nt at time of dea	death 3[□Ectopic pregnanc □ Other (specify) _	Py			1	Date of deliv	rery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition 5746-E	2	ath but not resul	iting in the u	nderlying cause gr	ven in Part I		III.	obacco use co 'es 2 🗆 No		the cause of death?
al Records,	The ele h	Completed								24a. Was a autop perfor	med2	b. Were autoprior to condeath?	opsy findings available ompletion if cause of
Vit	Physician: T rthis certificet ral director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Mosnital:		D(0. 44-	oti acino di	hon		Check only or			
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	To the Hospitel or Attendi within 24 hours effer deeth. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifier (Check only one)	g Physician: To the I Examiner: On the ba and mann	sis of examination	rledge, deat on and/or in	h occurred at the ti	me, date ar opinion, dea	nd place, a	and due to the c	cause(s) and date and plac	manner as : e, and due !	stated. to the cause(s)
)	To t To t	W	29b. Signature and title of certified	M.			29c. Licen		3		29d. Date sig		
Titles.			30. Name and address of person				Print)	2 (2	12 1	la Car	フレモ	DEI	9720
	Sta Registi		31. Date filed (Modifin, Day, Year) DEC 0 5	2006 37 Re	gistrar's Signatu	do.	ncurs						

			For State Registrer	State of Ma	aryland / Depa <i>Ce</i>	artment of H			giene Beg. No. 006	40280			
	Physici		Decedent's Name (First, Middle, Las Jack		nnis	Ritter		2. Date of Dea Month Decemb	ath Day Yea	M			
	/Medic Examin	79	4a. Facility Name (If not institution, give 818 Mt. Roya)	L Avenue,	Apt I	4b. City, Town, or Cumbe	rland	h	4c. County of De	4c. County of Death Allegany			
*	Funeral Director		5. Social Security Number 6. S 723-07-8918 Usual Residence of Decedent	5714 000	99 (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			lirthplace (State or Foreign CountryDistrict Columbia			
	Maryland -1 ehow lied at	tor	10a. State 10b. County MD Alle	gany	10c. City, Town or Lo	ocation umberland				10d. Inside City Limits 1 X Yes 2 □ No			
	with the a or 28a	Director	10e. Street and Number		A . T	10f. Zip Code	1500		10g. Citizen of What	Country?			
980	hours after death with the Maryland lurel', or Items 23s or 28s-1 show at Exeminating to motified at	by Funeral	818 Mt Royal 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Avenue, 12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	1502 spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	USA 14. Race - Ar Black, Wi	merican Indian, nite, etc. White			
Maryland 21215-0036	s within 72 jiene. r then "na	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or !	(Give life.	dent's Usual Occupa kind of work done of DO NDT use retired	turina most of wo	rking	16b. Kind of Busines	ss/Industry			
and	ould be filed Mental Hygi karked other katic event, I	Be	17. Father's Name (First, Middle, Last) Kenneth	Sco	tt Rit	er	18. Mother's Nar		Maiden Sumame) 'helma	Shriver			
Mary	and s m	To	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Ri	ural Route Numbe	er, City or Town, State	, Zip Code)			
Baltimore, N	of Heal of Heal of Item 2		Melvin L. Ritter 20a. Method of Disposition 1 Burial 2 Ocremation 3 C 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo cemetery, cre		e)	Date	rland, Tex 20c. Location - City of Cumberla	or Town, State			
Baltir	permit. Pag Department important: eny injury c gagg.		21. Signatur of Funeral Service Licer		2	2. Name and Addres	s of Facility A	dams Fam		al Home, P.A. 21502			
8760,	Priyaician // Medical Examiner	ilcal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Que to for s	a consequence of): A C C C C C C C C C C C C C C C C C C	Hear Son /	fil	lue 0950	lede m	Approximate Interval Between Onset and Death			
.O. Box 6	at the death certific by the attending p tached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	□Ectopic pregnancy			23d. Date of o Month	delivery Day Year			
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Div	itel or Attend irs after death rel Director: ,		4 Homicide determined	building, et	tc. (Specify)	redi, factory, diffes		City or Tov					
	To the Hospital or Atte within 24 hours atter de To the Funeral Directo Completely filled in by th	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of and manner st	of my knowledge, dea of examination and/or in tated.	th occurred at the time time of the time of time of the time of the time of the time of the time of the time of time of the time of time of the time of the time of time of time of the time of time o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)			
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0.	" 10° 10°		30. Name and address of person who Victor R. F	completed cause of a selipa, M.	death (Item 23a) (Type D. 925 R	Print) ishop Wal		. Cumber		21502			
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 4 2	32. Regist	rar's Signature			, - 3					

Amended #19a, MLU 12/04/06, Allegany Co. 1 - For State Registrar

Please

Type or Print in Black Inde	elible Ink. Ensure	e All Copies A	Are Legible.
State of Maryland / Depart	tment of Health an	nd Mental Hygi	ienen n n c

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e of Maryland / Department of Health and Mental Hygic	ene)	0		5	Beauti	01	2 0)
			U	\cup	lings #	U 6		ĵ
Continuate of Death Rec	a. No.							

	Physic /Medi Exami	ical
	uneral irector	
the Maryland	28a-f show	ractor

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death				
Physici: /Medic		EVANGELINE RATCLIFF		12	Day Year 02 06	4:20 A. M				
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	ıth				
		WMHS-BRADDOCK CAMPUS	CUMBERLAND		ALLEGANY	Z				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bit	rthplace (State or Foreign ountry)				
Director	ļ	230-42-0347 /8		DEC. 3,	1927 WE	ST VIRGINIA				
3		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d Inside City Limits				
o a	5	WV MINERAL RIDGEI								
28a-f	Directo	10e. Street and Number	10f. Zip Code	11	Og Citizen of Milat C	L				
10 M		ROUTE 3, BOX 283	26753	"		ountry:				
18 23	Funeral		J. Was Decedent of Hispanic Origin? (Sp	necify Yes or No-	U.S.A.					
	F.	Armed Forces? 1 Never Married 2 Married 1 Yes 2 MNo	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)						
0 9	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No Specify:		Specify: W	Birthplace (State or Foreign Country) Birthplace (State or Foreign Country) IEST VIRGINIA 10d. Inside City Limits 1				
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Ment urked utice	2	EUGENE MELVIN TWIGG	MAGDALI	ENE LOGS	SDON					
and in man		19a. Informant's Name/Relationship (Type, Print) HUSBAND	iling Address (Street and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)				
Health and Mental Hygiene. tem 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Modical Exporimer mount be notified at		JUSTIN M. RATCLIFF / HSBAND RO	OUTE 3, BOX 283, RI	DGELEY,	wv 26753					
		1 X Burial 2 □ Cremation 3 □ Bernoval from State	rematory or other place)		20c. Location - City or	Town, State				
Department of important: If I eny injury or once.		4 □ Donation 5 □ Other (Specify) FORT AS:	HBY CEMETERY 12/07	7/2006	FORT AS	HBY, WV				
Department Important: I eny injury c		21. Signature of Funeral Service, licentee	22. Name and Address of Facility UPCHURCH FUNERAL	HOME IN	JC.					
0 = 9 9		Gendy Fi tepcherco	P.O. BOX 1260, FO	ORT ASHBY	WV 26719					
		23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Interval Between				
nysician		Immediate Cause (Final disease or condition CHRONIC OBSTR	ICTIVE PULMONA	RY DIS	EASE	100				
Medical		resulting in death) Due to (or as a consequence of):		, , , , , , ,	,5-	100				
xaminer		Sequentially list conditions.								
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and -tran	Cam	Cause (Disease or injury that initiated events c								
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physicien and s the burial-transit	clan/Medical	d								
ettending p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			024 0-444-	15				
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signed by the e Id be detached f	P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?				
sign Id be	d by	Metastetre Bone Disease		1 □ Ye	s 2 □ No 3 📉 P	robably 4 Unknown				
beel shou	ete			24a. Was ar	24b. Were a	utoosy findings available				
page 2	Completed			autops	y prior to ned? death?	completion of cause of				
ificeti or. pa	ပိ	25. Was case referred to medical	00 81	1 ☐ Yes 2		s 2 No				
n. After this certificete hes been si funeral director, page 2 should	ToB	examiner? 1 ☐ Yes 25€No Hospital: 1 €4npatient 2 ☐ ER/Outpat	100		nce 6 ⊡Other (Spe	noile it				
ar this aral o		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe ho		эспуу				
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r dea ector	100	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm,	street, factory, office			ural Route Number,				
within 24 hours effer death To the Funeral Director; completely filled in by the	Certification;	4 Homicide Solomines building, etc. (Specify)		City or Town	, State)					
within 24 hours effer death. To the Funeral Director; A completely filled in by the fu	al	29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place,	and due to the ca	use(s) and manner a	s stated.				
n 24 he Fu	edlcal	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)				
with To 1	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Mon					
		Vaul J. Twergood mD	023774	D_{i}	ECEMBER	2,2006				
3		30. Name and address of person who completed cause of death (Item 23a) (Typ								
		PAULT. LIVENGOOD MD 912 SETON DRIV	E CUMBERLAND	MARYLAN	D 21502					
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature								
Registr		DEC 0 4 2006 Magnes 16	Grade .							
117 Day 1/2	001									

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Jose De Jesus Colorado Ruiz 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 18, 2006 1545 hrs Medical Examiner Jesus Colorado Jose de 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8650 Piney Branch Rd Apt. 202 Silver Spring Montgomery Date of Birth(MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Mexico 2/17/1983 Months Hours 23 Director 537-99-7265 1 XM Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County Md Prince George Bladensburg Yes 2 XNo 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 54th Place 20710 Mexico 4304 Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Yes 2 X No White Mexican If Yes, Give Yea 1 X Yes 2 No specify: Specify Widowed 4 Divorced <u>δ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Porcelain Elementary/Secondary (0-12) College (1-4 or 5+) Refinishing MD 21215-0036 Technician 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jose de Jesus Colorado Villanueva Asuncion Ruiz Castillo Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a. Informant's Name/Relationship (Type, Print) Humberto Gomez/Cousin 4304 54th Place Bladensburg, Md. 20710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) XBurial 2 Cremation 3 XRemoval from State Cemeterio Las Lomas12/07/06 Veracruz, Mexico Other Specif PHTLTPdd D. KINALDI FUNERAL SERVICE, P.A. 21. Signat e of Funeral Service 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line /Medical Death a Methylene chloride Toxicity complicating Dilated Cardiomegaly Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown pleted 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Com Yes 2 **~** 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes No 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Exposure to toxic fumes FOUND: 1 Natural 1 ✓ Yes 2 No 5 Pending 2 🗸 Accident Nov 18, 2006 1535 hrs Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 8650 Piney Branch Rd Apt. 202, Silver Spring, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. November 19, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Mon 1997) istrar's Signature State Registra

		State of Maryla 1- State Amend item#8, perFH, (%62, 12/ Registrar	and / Depa 18/06 17 <i>Cei</i>	artment of H rtificate of L	ealth and Death	Mental Hyg	giene ()	06	402	83
Dhuniai		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith Day	Year	3. Time of D	eath
Physicia /Medic		James Ray	nes			12	07	06	0339	М
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County of Death						
		WMHS-Braddock Campus		Cumber1				legany	7	
Funeral		E70 20 0225 XUM 2015	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rear)	9. Birthp	lace (State or I	Foreign
Director	}	370-30-0333	115.			Dec. /r	2006	ATEC	JIIIIa	
and w		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				T1	0d. Inside City	Limits
Mary f ehe	ō	MD Allegany F	rostburg	a					1 ☐ Yes 2	X No
286-	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Coun	try?	
death with the Maryland ms 23a or 28e-f ehow final be notified		17011 Beechers Avenue		21532	2		USA			
1036 Ours after death with the Marylan rel', or Items 23s or 28e-1 ehow Examiner invest be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	μs. 13.	Was Decedent of Hill If Yes, specify Cubar	spanic Origin? ((Specify Yes or No-	14. Ra	ce - Americ		
or its		1 ☐ Never Married 2 🔀 Married 🗶 ☐ Yes 2 ☐ No		ir Yes, specify Cubai 1 □ Yes 2 A No	Specify:	ento Filcan, etc.)		ack, White,		
OU36 hours after turel; or ite	d by	3 Widowed 4 Divorced Year or Dates:	952	163 26140	эрвспу.		Speci	[∱] Whit	:e	
21215-0036 4 within 72 hours aftiene. r than "naturel", or the Madical Erection	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d	turing most of w	orking	16b. Kind of i	Business/Ind	lustry	
within 72 ene.	m m	Elementary/Secondary (0-12) College (1-4or 5+)	100	DO NOT use retired,)		(T)	c		
filed v Hygie Sthert		17. Father's Name (First, Middle, Last)	Truci	c Driver	19 Mathada N	ame (First, Middle,	Transi			
DDE	Be	James C. Raynes				M. (Mille				
Mark Mark	၉	19a. Informant's Name/Relationship (Type, Print)	10h Mailie	ng Address (Street a					Codol	
Mar d 2 sho th and 7 ie m treum		Betty J. Raynes		l Beechers						
a a a a	16		. Place of Dispo	sition (Name of	1	Date	20c. Location			
Pages Pages nent of int: If it		1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State	_	natory or other place O Vet Cem		11,2006	Flints			
Baltimore, permit. Pages 1 a Department of Het Important: If tem eny inlury or othe once.	- 1	4 □ Donation 5 □ Other (Specify) Ri 21. Signature of Fuperal Service Licensee		2. Name and Addres						
Baltimore permit. Pages 1 Department of H Important: If ite eny injury or ott	Ų,	John J. Tatalon C		302 Nation				.vice, 21502	PA	į,
		23a. Parti. Enter the disease, or complications that caused the d				·		-1302	Approximate	
Physician		shock, or heart failure. List bnly one cause on each line. Immediate Cause (Final	Tair	MAR	FII	21111	ATTO	N	Onset and De	aen ath
/Medical		resulting in death)	sequence of):	VUIII	, , , ,		777			
Examiner		CAN	7							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	sequence of):	EPEND	-410	TW. VI	ma			
18 760, cate be executed physicien end the burial-fransit	Examln	that initiated events c.		EPEND	STYV	SIII DI	1700	765		
SO,		resulting in death) Last Due to (or as a cons	sequence of):							
8760 sate be e physicien the burit	dlcal	d					·		-	
D 🚊 🙃 🛭	Me	IF FEMALE: 23c. If yes, outcome of pre-	202004							
BOX sath cert attendin for use	lan	in the past 12 months?	etal death 3	Ectopic pregnancy			1	ate of delive onth	ry Day Ye	ar
. 0 0 0	Physiclan/Me	1 Yes 2 No 9 Unknown 9 Unknown	ordeath 5	Other (specify)						
Ords, P.O. I requires that the despensioned by the a hould be detached to	H.	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of dea	ath?
VITAI KECOLGS, sicien: The law requires t certificete has been signs rector, page 2 should be	d by	HUPERTENSION				1 🗆 Y	es 2 🗆 No	3 Prob	ably 4 🖭	iknown
	Completed	HUPENIDINA	MA			24a. Was a	24h	Ware auto	sev findings av	raulable
Hec The law ste has t	E D	THE ENCE THE	, ,			autops	sy med?	death?	osy findings av	ise of
VITAI REC sicien: The law certilicete has t irector, page 2 s	e Co	25. Was case referred to medical				1 ☐ Yes		1 🗆 Yes	2 No	
	00	examinate	VETVOutpatier	othe Othe		eath (Check only or				
	٦: <u>۲</u>	27. Manner & Death 28a. Date of Injury (Month, Day Year		IL 30 DOX	4 🗆 Nursing	Home 5 Resid			")	
SION (Itending F death. tor: After the funera	皇	1 Matural 5 Pending (Month, Day Year 2 Accident investigation) Injury		(? Yes 2∐No		, ,			
DIVISION Tor Attending effer death. Director: After din by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - A	t home, farm, str	eet, factory, office		28f. Location (S		ber or Rura	l Route Numbe	a <i>r</i> ,
in Distance	Certification:	4 Homicide building, etc. (Spe	эсігу)			City or Tow	n, State)			
Hospital of thours element Ele		29a. Certifier (Check only 2 Medical Examiner: On the basis of exam	cnowledge, death	h occurred at the tim	ne, date and place	ce, and due to the c	ause(s) and m	anner as st	ated.	
TAFF	Medical	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	ination and/or in	vestigation, in my op	oinion, death occ	curred at the time, o	late and place	, and due to	the cause(s)	
To the within 2 To the complet	Σ	29b. Signature and title of certifier	M	29c. License	number	d	29d. Date rign	ed (Month, I	Day, Year)	
				11/2	116	/	40	10/	0	
1119		30. Name and a dress of person who completed cause of death (I	tem 23a) (Type,	Print)	NES,	BRNI	40	115	VIII'S	SK
2+19 Sta		30. Name and a dress of person who completed cause of death (I	151	Print)	NES, BRAL	BOOL	no	NET ANJ	CINY PUS	SIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Me	arylana /	-	ificate of l	Death		Reg. No.	16 40284
			1. Decedent's Name (First, Midd	dle, Last)					2. Date of Dea Month		3. Time of Death
	Physicia /Medic	_	Mary E Sti	gleman					Novemb	er 30 2	006 4:52 PM
	Examin	- 14	4a. Facility Name (If not institution					Location of Death	1	4c. County of	
	A Town	12.5		Memorial He			Frede	rick If Under 24 Hrs.	8. Date of Birth	Frede	
	Funeral Director		5. Social Security Number 305–26–0079	6. Sex 7. Age 1	77	Yrs.	Months Days	Hours Min.	Month, Day Dec. 23	3,1928	e. Birthplace (State or Foreign Country) Indiana
	/land ow at		Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, To	wn or Loca	ation				10d. Inside City Limits
	a-f sh lifted	ctor	Indiana Wayne	2	Ric	chmon	d				1 X Yes 2 No
	th the)ire	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
	ath wi	Funeral Director	1138 Abington				4737				SA
	er de	nue	11. Marital Status	12. Was Decedent E Armed Forces? arried 1 ☐ Yes 2 ☑ 1		13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	. 14. Hace - Black,	American Indian, White, etc.
2	be filed within 72 hours after death with the Maryland Hygliene. Hygliene. do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, Give	10	1	□Yes 21xxNo	Specify:		Specify:	White
	72 ho natur dical l	Completed	15. Decede (Specify only high	ent's Education lest grade completed)	16	a. Decede	ent's Usual Occup	ation during most of wor	king	16b. Kind of Busin	ness/Industry
1	- 4 60	ld m	Elementary/Secondary (0-12)	1	+)			1)			- 4
7	filed v Hygie ther t		12 17. Father's Name (<i>First, Middle</i>	e, Last)		Ins	pector	18. Mother's Nar	ne (First, Middle,	Manuia Maiden Surname)	cturing
3	d be ental ked o c eve	To Be	John R		ith			Stell	a E.	Sho	res
	shoul ind M i marl umati	F	19a. Informant's Name/Relation			9b. Mailing	Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, St	ate, Zip Code)
	and 2 rath a 27 is er tra		Kathleen McDona	ald/Daughter			Devon La		kersvill	e, MD 21	793
5	of He fitem		20a. Method of Disposition	3 □Removal from State			ition (Name of atory or other plac		Date	20c. Location - Ci	
	Pag fment tant: I		4 □ Donation 5 □ Other	(Specify)	Glen	Have	n Mem. (Gard 12/8	3/2006	Boston,	
3	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce.		21. Signature of Funeral Service	4 Co				ss of Facility St sumtown		uneral H Frederick	, MD 21702
Ī			23a. Part Enley the disease,	or complications that caused st only one cause on each lin	the death. Do	o not enter	r the mode of dyir	ng, such as cardia	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ather	oscler	coti	· lare	linuses	ular 8	Disease	Oncot and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequenc	ce of):					Tears
		er	Sequentially list conditions, if any, leading to immediate	b	a consequenc	ce of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1							
5	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a consequenc	e of):					
5	ate be rhysici the bu	Medical		d							
<	sertific ding p	/Me	IF FEMALE:	23c. If yes, outcome	nf pregnancy					001.5	
ב	leath cer attendin I for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	/		23d. Date of Month	
į	t the d by the ached	hysi	9 ☐ Unknown	9□Unknown							
,	e law requires that the de has been signed by the a je 2 should be detached	by P	Part II. Other significant cond	tions contributing to death be	ut not resulting	g in the und	derlying cause giv	en in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
Ś	equire en sig ould b				.				1)(X)	Yes 2□No 3	☐ Probably 4 ☐ Unknown
2	law r nas be	Completed							24a. Was autop	an 24b. We	ere autopsy findings available or to completion of cause of ath?
	: The cate to page	Con							perfo	med? dea 2 No 1 L	ath? Yes 2No
2	stcian certifi rector	Be	25. Was case referred to medic examiner?	Hospital:			3 DOA Oth	or:	ath (Check only of		•
5	Phys rrthis eral di	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ry 28t	o. Time of	3 □ DOA Oth 28c. Injur Wor	4 Li Nuising F	T	dence 6 Other	
5	nding th. :: Afte e fune	tion	1 Natural 5 ☐ Pend	ling (Month, Day stigation	Year)	Injury		ḱ? Yes 2∐No			
2	er dea rector	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be rmined 28e. Place of inju- building, etc	ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number	or Rural Route Number,
5	ital or irs afte ral Di	Cert									
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certify (Check only one)	ring Physician: To the best al Examiner: On the basis of and manner sta	f examination	dge, death and/or inve	occurred at the tile estigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certi	fier			29c. Licens	e number		29d. Date signed ((Month, Day, Year)
	_		alan	Kalires	MD:	DM	且D3	7197		Novemb	per 30, 2006
			30. Name and address of person	on who completed cause of d	eath (Item 23a	a) (Type, P	rint) 7th	Street	Frede	rick	Month, Day, Year) Der 30, 2006 MD 21701
	Sta Registr		31. Date filed (Month, Day, Yea	5 2006 32. Figistr	ar's Signature	1	relle)			1	
	1109101		DEC	A PACE	~ ~	197	-				

7.3	4	_	~	~	gr.on
State of Maryland / Department of Health and Mental Hygiene 2006	l.j	U	2	8	5
Certificate of Death					

			For State Registrar	State of Ma		epartment of Ce <i>rtificate o</i>			giene∠ U U I Reg. No.	0 40700		
			1. Decedent's Name (First, Middle, Last)	ath Day Year	3. Time of Death						
	Physicia /Medic		Richard B. Si			Decem	ecember 3,2006 11:3					
	Examin		4a. Facility Name (If not institution, give	4b. City, Town	, or Location of D	eath	4c. County of De					
			Union Hospit			E1k			Ceci			
	Funeral Director		217-20-3273	x 7. Age	73 Y	Months Day		Min. 8. Date of Bird (Month, Da March	v. Year)	rthplace (State or Foreign Country) MD		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits		
	8e-f eho	Director	MD Ceci	1	E1kto					1 ☐ Yes 2 🙀 No		
	with ti	ă	10e. Street and Number			10f. Zip Code	921		10g. Citizen of What Country?			
	eath	erai	14 Woods Way	12. Was Decedent B	ever in 11 S			2 (Specify Ves or No	U.S.A.	nerican Indian,		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at since.	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	1948-	If Yes, specify C		? (Specify Yes or No Juerto Rican, etc.)				
2	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ication	16a. D	ecedent's Usual Occ	upation	working	16b. Kind of Busines	s/Industry		
Maryland 21215-0036	d within giene.	Completed	Elementary/Secondary (0-12)	+)	fe. DO NOT use ret Forklif	red)		Chrysle	er			
힏	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Sumame)				
<u>X</u>	Ment Ment arkec	L 2	Irvin H. Sim	mons			Hil	lda M. B	1ackson			
Baltimore, Mar	2 sh la m la m		19a. Informant's Name/Relationship (T)						er, City or Town, State,	Zip Code)		
	l and lealth im 27 her ti		Louise P. Simm 20a. Method of Disposition	ons/Wife		WOODS Disposition (Name of	Way, El	lkton, M		T		
	if its		Burial 2 ☐ Cremation 3 ☐ F		cemetery,	crematory or other p		ecember	20c. Location - City of			
	rtmer rtant njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		PIKCOI	22. Name and Add		, 2006	Elkton,	MD		
Ba	Depa Impo) Allo			Andrew	G. Geé	Funera1				
ï			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. Do no	t enter the mode of c	Maln St ying, such as car	to, Elktodiac or respiratory ar	on, MD 2	2 1 9 2 1 Approximate		
	Physician		Immediate Cause (Final disease or condition	ne cause on each lin	Tut-	Must	red v	1/2/04	upon	Interval Between Onset and Death		
	/Medical		resulting in death)	Due to (or as	a consequence of		7 7 0 7 3	(,0,1)	V-07. V	1		
н	Examiner		Sequentially list conditions	b	Meno	scleusi)			(year)		
	of the	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	:						
	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of							
68760,	ficate be executed physicien and is the burial-transit	al E		Due 10 (01 as a	a consequence of	•						
387	phys s the	edical		d								
Box	certif nding use a	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	alivery		
P.O. Bo	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	3 ☐ Ectopic pregna 5 ☐ Other (specify)			Month Day Year					
ري ح	s that ned b e deta	by PI	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in t	he underlying cause	given in Part I.	23e. Did to	obacco use contribute	to the cause of death?		
Ę	w require been sig should b	ed					-	101	res 2 No 3 F	robably 4 Hunknown		
ပ္တ	awre	plet						24a. Was	an 24b. Were a	utopsy findings available		
Division of Vital Records,	The lavete has	Completed							rmed? death? 2⊠No 1□Ye			
ita	iclan: Th certificete rector, pag	Be (25. Was case referred to medical examiner?				26. Place of	Death (Check only o				
<u>></u>	hysic this o	2	1 □ Yes 2 No	Hospital: 1 ☐ Inpatie		Allent 3 DOA			dence 6 Other (Sp	ecity)		
Z	Attending Physiclan: r death. ector: After this certifice by the funeral director,	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Tin (<i>Year</i>) Inju	ıry V		28d. Describe h	28d. Describe how injury occurred			
S	or Attendated after death Director: in by the	Ical	2 Accident investigation 3 Suicide 6 Could not be	Inv - At home farm	n, street, factory, office	□Yes 2□No	28f Location (9	28f. Location (Street and Number or Rural Route Number.				
<u>S</u>	after Direct	Certification:	4 Homicide determined	. (Specify)	., street, ractory, Utilic	•	City or Tow		our rivers runnust,			
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best of	of my knowledge,	death occurred at the	time, date and p	lace, and due to the	cause(s) and manner a	as stated.		
	he Hi in 24 he Fi	ledicai	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/ ted.	or investigation, in m	opinion, death o	occurred at the time,	date and place, and du	e to the cause(s)		
	S the	≥	29b. Signature and title of certifier	\		29c. Lice	nse number		29d. Date signed (Mor	nth, Day, Year)		
\	F 3 F 0	1	I HAND	J W			MI (-1)		Da i	3,2006		

6+1VA

State Registrar

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Or. A Shok Subramanian 10

31. Date filed (Month, Day, Year)

DEC 0 5 2006

Subram Signature

DEC 0 5 2006

106 Bow St. Elkton, mo

21921

		For State Registrar		of Maryland	/ Depa		of H	ealth a	and M	ental Hyg	,	006	402	86
		1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ıth		3. Time of D	eath
Physic /Medi		Hazel A	Seller	S						Month 12	O1	Year 06	0115	М
Exami		4a. Facility Name (If not institution	, give street and no	ımber)		4b. City, 7	Town, or	Location	of Death		4c. Cou	nty of Deat	h	
		WMHS Braddock					ber1					egany		
Funeral Director		5. Social Security Number 207-24-2007	6. Sex 1 ☐ M 2. X F	7. Age (In yrs. las	Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day 8-25-1		9. Birtl Co	hplace (State or F untry) PA	-огвідп
show	o.	Usual Residence of Decedent 10a. State 10b. County PA Bedfor	rd.	10c. City,		cation Mill) <u>,</u>						10d. Inside City	
the N	ect	10e. Street and Number			0 00000	10f. Zip					10a Citizan	of What Co		
with	ā	7369 Hyndman		TOT. Zip	155	21			10g. Citizen of What Country?					
death ms 2;	era	11. Marital Status	12. Was Dec	cedent Ever in U.S.	13. \	Was Decede			igin? (Spe	cify Yes or No- Rican, etc.)	14. F	ISA lace - Ame	rican Indian,	
permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show ship highty or other traumatic svent, the Medical Evanting must be rediffied at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed F ned 1 ☐ Yes If Yes, G Year or t	2 ⊠No ive		fYes, speci 1□Yes 2	_	Specify:		Rican, etc.)	Spe	llack, White c <i>ify:</i>	e, etc. Thite	
"natura	leted	15. Deceden (Specify only highe:	t's Education st grade completed,		16a. Deced	dent's Usual kind of worl DO NOT use	Occupa k done di	tion uring mos	t of workir	ng	16b. Kind of	Business/	Industry	
d withir giene. r then	omp	Elementary/Secondary (0-12)	College	(1-4or 5+)		emaker					Own	Home."		
be filed ntal Hygi nd other svsnt, I	Be C	17. Father's Name (First, Middle, Harry Trundle	Last)				1	18. Mothe	er's Name	(First, Middle,				
ould be Mental Marked c	2	Dora Fry												
d 2 sh th and th and 17 is rr trsurr		19a. Informant's Name/Relations HOURY Sellers				-				I Route Numbe ILO Mil				
s 1 an f Heal ftsm 2 other		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Nam	e of			ate	20c. Locatio			
Peges nent of nnt: If it ury or o		1 🔀 Burial 2 □ Cremation 4 □ Donation — 🕻 □ Other (S		State		natory`or ou Cemter		· 1	12-4-	-2006	Anmaa	h DA		
permit. Pege Depertment of Important: If any Injury or once.		21. Signatury of Fundral Service		lous	22	. Name and	Address	s of Facili	ty 160	9 Clare	nce St	. Hyn	dman PA	15
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Betwee Onset and De	en ath	
ite be executed ysicien and he burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequer	nce of):		<i>Δ11</i>	۵ (Lt	TI U			IX PHY	
Attending Priysician: The law requires that the death certifica tradesth. ratesth. actor: After this certificate has been signed by the attending phistor. After this certificate bas been signed by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnapt in the past 12 months? 1 Yes 2 Uhro	1 Live	utcome of pregnance birth 2 Fetal de inant at time of deat nown	eath 3	Ectopic pre Other (spe						Date of deli Month	very Day Yea	ar
quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions. 1 Yes 2 1040									the cause of dea			
The law requir sate has been si page 2 should I	Completed	DIABATES MULTUS INSULUN RUQUIRUM 24a. Was an autopsy performed? 1 Yes 20070 dea								prior to c death?	topsy findings avionabletion of cause	ailable se of		
iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death	Check only or				
Physi this c	은	1 Yes 2 1 16	-		VOutpatien			4 🗆 140		ne 5 Resid			erfy)	
itending Physician: Jeath. tor: After this certifica the funeral director, p	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No							urred					
al or Atto	Certific	3 Suicide 4 Homicide 6 Could not be determined 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Num City or Town, State)								ral Route Numbe	r,			
To the Hospital or Attenwithin 24 hours efter deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)	Examiner: On the t	e best of my knowle pasis of examination oner stated.	edge, death n and/or inv	occurred a restigation,	t the time	e, date an inion, dea	d place, a	nd due to the c	ause(s) and late and place	manner as e, and due	stated. to the cause(s)	
Vith Com	Σ	29b. Signature and title of certified	DA	pitysica.	AN		License		PUC		9d. Date sign			0
(5)		30. Name and address of person	who completed cau	se of death (Item 23	3a) (Type,	Print)	MD	91	250	TON DIZI	VE CI	MBFI	1/2006 NAND ND	215
Sta		31. Date filed (Month, Day, Year)	32.1	Registrar's Signatur						- 1 - 1	- 00		-1/1/45 1-07	-1,31
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			1 - For State Registrar	State of	Maryland		artment of I		nd Me	_	jiene	006	40	287
			1. Decedent's Name (First, Middle	, Last)					2	. Date of Dea		Vana	3. Time	of Death
	Physici /Medio		Stephen John Sze	epesi						Month Novembe	Day	Year 2006	6:15	рм
Ý.	Examir		4a. Facility Name (If not institution	, give street and num	iber)		4b. City, Town,	or Location of	Death	NOVEMBE		County of Deat		
			Washington Advent	ist Hospita	1		Takom	na Park				Montgom	02757	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24		Date of Birth	1 Voorl	9. Birt	hplace (State	or Foreign
	Director		263-42-1448	1 G ₂ M 2 □ F	75	Yrs.	Months Days	Hours	Min. ZΔ1	(Month, Day 19. 1, 1		-	untry) cticut	
	ַ ק		Usual Residence of Decedent											
	urylau phow	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside	
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	or ith	Director	10e. Street and Number				10f. Zip Code			1	10g. Citiz	en of What Co	untry?	
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	tema er de	Funeral	11. Marital Status	Armed For	dent Ever in U.: ces?		Was Decedent of If Yes, specify Cut	Hispanic Origi pan, Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)	1	 Race - Ame Black, White 		
36	or l	by Fi	1 Never Married 2 Marri	ed 1 TYes If Yes, Give	² □No Korean	1	1 ☐ Yes 2 ☐ No	Specify:				Specif W hite		
Ö	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow than Medical Exertii or mail te mailfied at		3 Widowed 4 Divorced	18al Of Da	tes: Confli	ct								
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7	within and them	mc.	Elementary/Secondary (0-12)	College (1-	4or 5+)		truction W	,			Commo	rcial Co	netnet	ion
2 2	Hygie other t		17. Father's Name (First, Middle, I	Last)		CO.15	CI CC CICII W	T	's Name (F	First, Middle,			IISCI CICC.	1011
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other than "natural", or Itema 23a or 28a-1 show aumatic event, the Madical Examili of Irinal La notified at	င္	Stephen John Szepe 19a. Informant's Name/Relationsh			19b. Maitir	ng Address (Stree		Sue Gr		r. City or	Town State Z	in Code)	
<u>8</u>			Victoria Aparicio		=_		201							2
စ်	1 and Health Iem 27 other to		20a. Method of Disposition	szepesi/ wii	20b. Pl	ace of Dispo	Ham shire sition (Name of		Date			ation - City or		3
ᅙ	Pages nent of ant: If it		1 Burial 2 Cremation		state [natory or other pla n Cremator	IN	ovembe	10	7.1 ov	andria,	Vizorini:	_
Baltimore,	and in C	/	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I		1200	-			2006			aidi Ia,	virgina	a
Ba	Departme Departme Importer eny injur			0			Name and Addr							
			23a. Part1. Enter the disease, or	complications that ca	used the death		00 Univers					, MD 209	O1 Approxima	ate
			shock, or heart failure. List to the time the transfer of the	only one cause on ea	ich line.	50 1101 0111	or 1.10 111000 or 0,	g, 50025 o.	214140 01 11	oophatory an	001,		Interval Be Onset and	etween
Miller	Physician /Medical		disease or condition resulting in death)		Tampona									
	Examiner				oras a consequ y Artery		۵							
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	ted	Examiner	cause (Disease or injury											
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8760	ate be executed hysicien and the burial-transit	dicai												
98	the the	g		d										
×	requires that the death certific sen signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo							23	3d. Date of deli	verv	
Вох	atter after	ciai	in the past 12 months?		rth 2∏Fetal ant at time of de]Ectopic pregnand] Other (specify) _	cy .				Month	Day	Year
o.	the d y the tchec	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno										
<u>ה</u>	res that the de signed by the a be detached to		Part II. Other significant condition	ns contributing to de	ath but not resu	Iting in the u	nderlying cause g	ven in Part I.		23e. Did tol	bacco us	e contribute to	the cause of	death?
ŝ	uires n sign	d by								1 🗆 Ye	es 2	No 3∏Pro	obably 4]Unknown
် လ	w require been sig	lete								24a. Was a	n	24b. Were au	toney finding	s available
Ä	The law ste hes b	Completed				-			_	autops	sy	prior to death?	completion of	cause of
Ø			25. Was case referred to medical								2 No No	1 🗆 Yes	2 No	
₹	sicia cert	o Be	examiner? 1 Yes 2 No	Hospital: XX	patient 2 🗆 l	TD/Output	Ot	hon		Check only on		70.1 10		
Division of Vital Records,	Attending Physician: r death. ector: After this certific by the funeral director.	. To	27. Manner of Death	28a, Date o	f tnjury	ER/Outpatien 28b. Time of	IL SLI DOM	4 🔲 NUIS		J. Describe ho		Other (Spec	city)	
<u></u>	ding P. Afte	ţ	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month	n, Day Year)	Intury	28c. Inju Wo	ork?]Yes 2.∐No	1		,-,			
<u> S</u>	Attendi death. ctor: A	Certification:	3 ☐ Suicide 6 ☐ Could r	not be 28e. Ptace	of Injury - At ho	me, farm, str	eet, factory, office		28f	Location (SI	treet and	Number or Ru	ral Route Nu	mber,
á	after after Dire	erti	4 Homicide	buitdin	g, etc. (Specify)	,			City or Towi	n, State)			
	Hospital		29a. Certifier 1 Certifyin	g Physician: To the	best of my know	wledge, death	n occurred at the t	ime, date and	place, and	due to the c	ause(s) a	nd manner as	stated.	
	• Ho • Fu • Fu letely	edicai	one) 2 Medical I	Examiner: On the ba and mann	sis of examinat	ion and/or in	vestigation, in my	opinion, death	occurred	at the time, d	ate and	place, and due	to the cause	(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	₩	29b. Signature and title of certifi	3			29c. Licen	se number		2	9d. Date	signed (Month	n, Day, Year)	
			\rightarrow d	Kado'			290	SOS	7	1	Voveml	œr 25, 2	2006	
- /	3+1		30. Name and address of person	who completed as	of death (Item	23a) (Type	Print)	U B P.	١					
			Anjum G. Qazi, M.	/			akoma Park	,MD 2091:	2					
p P	Sta	te	31. Date filed (Month, Day, Year)											
	Registi	ar	UEU -	1 2006	gistrar's Signat	OF A	and I							

			For 1_ State	State of Marylar		artment of H		l Mental Hy		2006	402	88
			Registrar 1. Decedent's Name (First, Middle, Las		Timouto or E		2. Date of De	neg. No.				
I,	Physici		Angelette Margar			Month Novem	Day Year 2006 3:39 a M					
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of De			County of Death		
	LAUIIIII		10012 Woodland D	rive	,	Silver Sp:	ring		ı	Montgome	ry	
76A	Funeral		5. Social Security Number 6. S	0 , ,					th v Vear)	9. Birth	nplace (State untry)	or Foreign
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	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 Cii	ty, Town or Lo	postion					10d Incide C	Site I impite
	aryla shov dat	_	Toa. State Tob. County	100.01	ty, rown or Ec	Callon					10d. Inside C	No 2√∑No
	he M 8a-f otifie	Director	Maryland Montgom	ery S:	ilver :	-			40 02	zen of What Cou		
	with t		10e. Street and Number	Desire		10f. Zip Code	2000	_	rog. Cit		untry?	
	be filled within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	10012 Woodland	12, Was Decedent Ever in U	S 13	Was Decedent of Hi	2090)- T	USA 14. Race - Amer	ican Indian.	
	ter d item	E	11. Marital Status 1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ▼ No		Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)		Black, White		
936	al", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify: Wh	ite	
ŏ	2 hou	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupa	ation		16b. Ki	nd of Business/I	ndustry	
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2	filed within 72 Hygiene. other than "na ont, the Medic	ĕ	12		Н	omemaker			Ov	n Home		
g	be file ital Hy id oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle	, Maiden	Surname)		
<u>X</u>	ould be filed Mental Hygi arked other atic event, t	2	Charles Droll				Margare	t Miller				
Maryland 21215-0036	2 should be and Mental is marked (raumatic ev		19a. Informant's Name/Relationship (Dan P. Stallings,	**	19b. Mailii	ng Address (Street a						000
<u>ح</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev once.				Disease of Disease	10012 Woo						902
Baltimore,	ges 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Hemovai irom State		osition (Name of matory or other plac	e) Dec	Date ember 5,		cation - City or 1		
ŧπ	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Specif		Gate of	f Heaven		'	Sil	ver Spri	ng, Ma	rylan
Ba	Dermi Mpo any li		21. Signati re o Funeral 5 rvice Licer	Leee Co.	Fi	and Address	SCOIIIn	s Funeral	l Hon	ne Inc.		
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			shock, or heart failure. List only	o e couse on each line.	in Boneton	ior ino mode or dyni	g, outil at our	ido or respiratory e	11001,		Interval Be Onset and	tween
	Physician / /Medical		disease or condition resulting in death)	a. Ovarian Due to (or as a consequence)		<u> </u>					6 Ye	ars
	Examiner			Due to (or as a conseq	quence or).							
0.5		-e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	quence of):							
	uted d ansit	Examiner	Due to (or as a consequence of): cause. Enter Underlying Couse (Disease or if Jury) that initiated events c.									
o,	e execan an an an an an an an an an		resulting in death) Last	Due to (or as a conseq	quence of):							
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		⊾d								
9	ertifica ing pl	Med	IF FEMALE:									
. Box	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnature 1 ☐ Live birth 2 ☐ Feta	al death 3	⊒Ectopic pregnancy			4	23d. Date of deliver Month	very Day	Year
0	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5L	Other (specify)					,	
_	that the sd by detac		Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of	death?
Records,	w requires that been signed to should be deta	l by	·		Ü	, , ,				☑ No 3 ☐ Pro		
Ö	v requestions	ete						24a. Was		Odb Ware out	loon, findings	available
Ř	: The law cate has I	Completed						auto		24b. Were aut prior to o death?	ompletion of	cause of
_	ician: Th certificate rector, pag		25. Was case referred to medical				Of Diagon of D	1 Yes	2 X IO	1 ☐ Yes	2 No	
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ö	g Phy er this eral o	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			ary)	
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Division or	r Atte er deg recto by th	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, str	reet, factory, office		28f. Location (City or To	Street an	d Number or Ru	ral Route Nur	mber,
5	tal ol rs afte al Di	Certification:		,				1		/		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is		(Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina								(s)
	thin 2 the mplet	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d Da	te signed (Month	Day Voor	
	7. ≥ 0.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		252. Gigilatare and in our certifier	2/2/		D296				mber 30		
,	12		30. Name and address of person who	JIV	- 22a\ /T							
	ia		Ralph Boccia, M.	D 6420 Rockle	edge Dr	ive, Beth	nesda, N	MD 20817				
	≈ Sta	ite	31. Date filed (Month, Day, Year)	32. Pegistrar's Signa		9						
	Registr	ar	DEC - 1	2006	M. A	DENTI						

State of Maryland / Department of Health and Mental Hydien & UU 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** December 9, 2006 2225 РМ Charles Lane Sprout /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Calvert Manor Healthcare Center Rising Sun If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. DEC 16, 191 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F 1914 Maryland Director 214-01-0812 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 TNo Director Marvland Ceci1 Port Deposit 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 71 Chad's Way 21904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1.10 = 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iter any injury or other treumatic event, the Medical Example. once. Armed Forces?
1 MYes 2 No World
II Yes, Give
Year or Dates: War II Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service 10 Maintenance 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Lewis Kirk Sprout Eleanor Saxton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Douglas Sprout/Son 236 Blake Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of commetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition December 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 13, 2006 Cherry Hill, Maryland ^{22.} Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signal re of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24a. Was an this certificate has autopsy performed Yes 2 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manper of Death 28d. Describe how injury occurred of or Attending Parafter death. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel of within 24 hours of To the Funerel D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

"Elimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D60768 2006 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.K. Jokhadar, M.D., 281 East Main Street, Rising Sun, Maryland 21911 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené UU 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:47 PM Daniel Shaffer December 10,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Lions Center for Rehabilitation Cumberland If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Sep 13, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1, M 2 F Ϋ́M̈́Ď Director 727-09-9699 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show treumatic event, the Medical Exercitive must be notified at MD Allegany Cumberland U∏Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21502 USA or Items 23a 105 Washington Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white Specify: þ 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Supervisor CSX Transportation marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be item 27 is marked o Margaret Collins Shaffer Charles D. Shaffer, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Washington Street Diane Shaffer wife Cumberland MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Importent: If it any injury or o ō 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/2006 Cumberland SS Peter Paul Cemetery 4 ☐ Donation 5 ☐ Other (Specify) MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a/Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediaté Cause (Final Physician Intraventricular Bleeding 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? t ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 24 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, this I Director: After the d in by the funera within 24 hours after death. To the Funerel Director: A

Medical

27. Manner of Death

1 Natural 2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier worsochefler

28a. Date of Injury (Month, Day Year)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

#D55325

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

December 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarn Terrace Frostburg, MD

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Wonsock MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

2006

5 Pending

investigation 6 Could not be determined

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 0 0 6 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Jack Birtolette Sutphin 07 2006 December 8:25 pM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth Jan. 30, Yea(1)945 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 1 M 2 □ F Virginia 223-62-2751 61 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frederick Frederick Maryland 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5404 Stone Road 21703 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1966—1969 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prison System State Government Elementary/Secondary (0-12) College (1-4or 5+) IndustryIndustrial Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Elizabeth Payne Jack Birtolette Sutphin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5404 Stone Road, Frederick, MD 21703 Mrs. Linda Sutphin, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Cardens 12/12/06 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses Keeney and Basiord PA Funeral Home sulwide (106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Derys Kespiratorn Due to (or as a consequence Sequentially list conditions se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1∐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2, **√**√0 1 Inpatient 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examine The law requires that the death certificate be executed and burial-tran physician Records, P.O. Box 68760 Physician/Medical the aftending p detached þ þe page 2 should Completed has certificate **Division or Vital** Be ၉ this

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Attending

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

death.

Certification:

Medical

Physician

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Examiner

Funeral

Director

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items 23a

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12 should be filed what and Mental Hygies Is marked other the

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any linjury or other traumatic evone.

Physician

/Medical

Examiner

the Medical

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funera

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Completed

Be

25. Was case referred to medical examiner?

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

29b. Signature and title of certifier

DEC

4 ☐ Homicide

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnson Drive Frederick, MD 21702 46B 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

		Please						Ensure A	-		_	
		For State Registrar	State 0	i iviai yiai		arımer rtifica:		ealth and l Death	wentai Hy	ygien Reg. N		1 0000
8		Decedent's Name (First, Middle, La.	st)						2. Date of D	eath	ay Year	3. Time of Death
Physicia /Medic		Augusta Francis							Novem	ber_	26, 200	
Examin		4a. Fecility Name (If not institution, giv 3813 10th Street				Ches	apea]	ke Beach				vert
Funeral Director		5. Social Security Number 214-05-1698 Usual Residence of Decedent	ex □M 2XTXF	7. Age (<i>In yrs</i> . 95	Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Year	1911 Ma	thplace (State or Foreign ountry) ryland
death with the Maryland rms 23a or 28a-f show r must be notified at	ctor	10a. State 10b. County Maryland Calver	t		y, Town or Lo sapeak		ıch	-	.,			10d. Inside City Limits 1 □ Yes 2XXNo
tn with the 23a or 28 ist be not	al Director	10e. Street and Number 3813 10th Street				10f. Zij	Code				itizen of What Co Lted Sta	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after 23 a or 28a-f show Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1\(\infty \) Never Married 2 Married 3 \(\begin{arrier} \text{Widowed} & 4 \end{arrier} \text{Divorced} \)	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	ZXNo		Was Dece If Yes, spe 1 ☐ Yes		spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	lo-	14. Race - Ame Black, Whi Specify: W	
nun 72 nou ne. han "natura e Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1	I-4or 5+)		kind of wo DO NOT u	ork done d ise retired	during most of wo)	rking		Kind of Business	,
Hygier W		17. Father's Name (First, Middle, Last	<u>4</u>] R	ecept	ioni	St 18. Mother's Nar	me (First, Middle	_	n Surname)	spital
uld be Vental rrked o	To Be	Walter L. Tyler						Mary M.	Bembe		,	
z sho n and h ls ma rauma		19a. Informant's Name/Relationship (Lawrence J. Kosma	20 /	Great				and Number or Re				
l and Health Iem 27 Sther t		20a. Method of Disposition	Ne ₁	phew 20b. I	Place of Dispo	sition (Na.	me of	1	esapeak Date		each, Ma	ry1and 20732 Town, State
rages lent of nt: If It		1 X Kunai 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		State I	cemetery, cire 11cres				/1/2006	Ann	apolis,	Maryland
ermit. epartm nportal ny Inju		21. Signature of Funeral Service Lice	• •		22	2. Name a	nd Addres	ss of Facility J	ohn M.	ray1	or Funer	cal Home,Inc.
20 5 6 5	\dashv	230 Barti Enter the disease or com	plications that o	raused the deat							nnapoli	s, MD 21401
hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. R	each line.	Hory	ar	eest		c or respiratory	arrest,		Approximate Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	Malia (or as a conseq	man uence of):	1-1	alie	le- Ky	yperte	n S	Oh	30 yrs
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g physician as the buria	ledical	•	d									
The law requires that the usern certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buna	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2/10 No 9 ☐ Unknown	1 ☐ Live b	come pf pregn pirth 2 Feta nant at time of cown	al death 3	∃Ectopic p ∃Other (s					23d. Date of de Month	livery Day Year
gned b	by P	Part II. Other significent conditions	contributing to de	eath but not res	ulting in the u	nderlying (cause give	en in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?
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trendil death. stor: A	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 28e Place	of injury - At h	ome farm str	М	1 🗆 '	Yes 2□No	20f Location	/Ctrant o	and Mumb as as D	unt Coute Number
o the hospina for Attending Priysician; within 24 hours after death, o the Funeral Director: After this certifica ompletely filled in by the funeral director,	Certification:	4 Homicide determined	buildi	ng, etc. (Speci	fy) 				City or To	ówn, Stai	te)	ural Route Number,
e nos 124 ho e Funciletely f	Medical	29a. Certifier 1 (Check only one) 1 Certifying Pl 2 Medical Example one)	niner: On the b	asis of examination as a stated.	ation and/or in	vestigation	n, in my o	pinion, death occi	e, and due to the urred at the time	e cause(e, date ai	s) and manner a nd place, and du	s stated. e to the cause(s)
withir To th	M	29b. Signature and title of certifier	K			29	c. License	number		29d. D	ate signed (Moni	th, Day, Year)
B		Many Li	- Kng	Jus C			D00	40904			1/27/20	006
(3)		30. Name and address of person who		e of death (Iter	n 23a) (Type,	Print)	214	03			/	
Sta		31. Date filed (Month, Day, Year)		legistrar/ Signa	ature	1		12				n
Registr	aľ		0 0 -00		PSS AND	1	Marine R.	1				

06-09261 Eric W. Thorpe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 5, 2006 Medical Examiner Eric Edward Thorpe 1000 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 8484 Georgia Avenue Silver Spring Montgomery 5 Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director 215-74-7098 cWarsh. D.C. 1X M 2 46 July 17, 1960 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits "natural", or items 23a or 28a-f show Examiner must be notified at once. 1 X Yes 2 No Maryland Montgomery Silver Spring hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 833 Woodside Parkway 20910 United States Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Never Married 2 Married 1X Yes No UKN Widowed 4 X Divorced Yes. Give Yea Yes 2X No specify: Specify Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than atic event, the Medical 21/2 Medical Billing Healthcare 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Earl H. Thorpe Juanita Ellis 19a Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (father) Earl H. Thorpe 833 Woodside Parkway, Silver Spring, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rock Creek Cemetery 12/9/06

Pages I and 2 should be filed within 72 I net of Health and Mental Hygiene ant: If iten 27 is marked other than "r ir other traumatic event, the Medical E. Baltimore, MD 21215-0036 Department of mportant:

/Medical

Donation 5 Other Specify

30. Name and address of person who combleted cause of death (Item 23a)

^{Year)} 2 2006

Theodore M. King, Jr., MD.

31. Date filed (Month Day

Physician Examiner

Box 68760

Division of Vital Records, P.O.

To the Hospital or Attending Physician:

hours after death.

2

21. Signature of Funeral Service Licenses 22. Name and Address of FacilitMcGuire Funeral Service omos 7400 Georgia Ave. N.W., Wash. D.C. 20012 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line Death Hypothermia Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and trai Physician/Medical ysician a burial -XUNPENDED AMENDED #23a,PII,27,28a-f, perME, g863, 1/23/07 TT phy: 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ⋧ Chronic alcoholism 1 Yes 2 No 3 Probably 4 V Unknown Completed has been s 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene ٩ 1 🗸 Yes 2 No After Manner of Death 28a Date of Injury (Month, Day, Year 28b Time of Injury 28d. Describe how injury occurred 28c. Injury at Work Certification: Natural Pending Yes 2 X No Director: FNd 12/5/2006 | Fnd 9:30 am subject exposed to cold environment 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8484 Georgia Ave. Silver Spring, MD 28e Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide within 24 hours at To the Funeral D determined (Specify) bench outside cafe' Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) OCME December 6, 2006

Washington, D.C.

State

Registrar

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Régistrar's Signatu

State of Maryland / Department of Health and Mental Hygiene 1- State Amend item#20b, perFH, G862, 12/18/00 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year ALPHONSO RICKEY TORRELL DEC 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LAURER REGISTAR HOSPITAR PMNLE GSORGE LAURBI 7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 9/14/1959 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**M** 2□ F Director 229-82-3127 VirginiA Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits rthen "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Prince George LAUrel 1 PQ Yes 2 □ No Director MAMANA lbe. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 13503 Aveburry Prive Apt 14 20708 or Iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "na any njury or other treumatic event, Ita Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Automob. le 12 MECLANIC 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alphonso Terrell II Makel JANE Mills 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13503 Areburny Dr. Apt. 14 Lanvel, MD 20708 CA-OLYN ANN 1crell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State mpdison beamstorn service 12/11/2006 4 ☐ Donation 5 ☐ Other (Specify) MAd-SUN. VA 22. Name and Address of Facility Preddy Funcin' Hume 21. Signature of Funeral Service Licensee E. Michael freelly CCC 449

Box 714 Country of eddy For 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Box 714 Courdonsv. 1/2, Up 22942 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SIRDER 2 WEEKS /Medical Due to (or as a consequence of): Examiner 4 WOBES STAPIHLO COCUS AVREUS Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last BAZY EREMIA Due to (or as a consequence of): Examine burial-transit STAPINGLOZOCCUS ANRESS Porsurana WEEK Due to (or as a consequence of): Box 68760, the attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown LIUSA DISOMS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 25tho 24a. Was an autopsy performed? 1 ☐ Yes 2 No Division of Vital or Attending Physiclen: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 □Yes 2 □No investigation 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á 4 Homicide To the Hospitel or within 24 hours aft To the Funerel Di completely filled in 1 Cartifying Physician: To the best of my knowledge, dettri occurred at the time, date and place, and due to the cause(s) and maker as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36974 DE26,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 205244 DAVID O. NYANJOM NO 15724 LITTLE PATUREMENT PARKENTY COLUMBIA
31. Date filed (Month Day Year) 2006 32. Registrar's Signalum 31. Date filed (Month, Day Year) DEC 18 State A State of State of Registrar

			For State Registrar	State	of Marylai		rtment <i>tificate</i>			Mental Hyg	giene () (06	4029	95
			Decedent's Name (First, Middle	, Last)						2. Date of Dea	ith	Year	3. Time of D	Death
	Physicia /Medic		John Bedford Wi	11oughby						Novembe	er 26,		3:00	A^{M}
	Examin		4a. Facility Name (If not institution	give street and nu	mber)		4b. City, To	own, or L	ocation of Deatl	n	4c. County	of Death		
			Anne Arundel Me				Annar					Arun		
	Funeral		5. Social Security Number	6. Sex 1.XXM 2□F		. last birthday) Yrs.	If Under 1 Months	Days	Hours Min.	(Month, Day	(Year)		lace (State or itry)	Foreign
	Director	-	125-01-0404 Usual Residence of Decedent		93	110.				Nov 24,	, 1913	Virg	ınıa	
	yland 10w		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City	Limits
	Mar B-f sh	tor	Maryland Anne	Arunde1	Anı	napolis							1 ☐ Yes 2	2 📉 No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Items 23a or 28a-f show aumatic event, the Medical Examination is an examined at	Funeral Directo	10e. Street and Number 85 Manresa Driv	e			10f. Zip C 214				10g. Citizen of United			
	ms 2:	nera	11. Marital Status	12. Was Dec	edent Ever in I	U.S. 13. V	Vas Decede	nt of His	panic Origin? (S , Mexican, Puerl	pecify Yes or No-	14. Ra	ce - Americ	an Indian,	
o	or Ite		1 Never Married 2 Marri	ed 1 Yes	2 No		Yes 2		Specify:	o ricali, etc.)		ck, White,		
2-00-c	ural',	d by	3 ☐ Widowed 4XXDivorced	Year or I	Dates: WWI	<u> </u>				1				
ה	"net	Completed	15. Decedent (Specify only highes	's Education t grade completed,		16a. Deced	ent's Usual kind of work OO NOT use	done du	ion iring most of wo	rking	16b. Kind of B	usiness/Ind	dustry	
V	withir ene. than	E C	Etementary/Secondary (0-12)	College (1-4or 5+)		tique		lor		Self E	mn1 ov	od	
2	filed Hygie other ant,	CC	17. Father's Name (First, Middle,			AII	rique_			ne (First, Middle,			eu	
yland	ld be ental ked c	To Be	Unknown					l N	Mary M.	Unknown				
ary	shou nd M mar	-	19a. Informant's Name/Relations	nip (Type, Print)				Street an	nd Number or Ru	ıral Route Numbe				
>	alth a alth a s 27 is er tra		Rodger Frantum	/ Friend		450	Delso	Cour	rt Anna	polis, M	larylan	1 214	09	
ore,	of He of He fiter r oth		20a. Method of Disposition	3 □Removal from	20b.	Place of Dispos cemetery, cren	sition (Name natory or oth	e of er place))	Date	20c. Location	- City or To	wn, State	
Ĕ	Pag ment ant: I ury o		M∑Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S)	pecify)	Cre					30/2006				
Банттог	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es		21. Signature of Funeral Service	icensee						hn M. Ta ster St.				
Г	-		23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	ath. Do not ente	er the mode	of dying,	such as cardia	or respiratory arr	rest,		Approximate Intervat Between	
	Physician	104	tmmediate Cause (Final disease or condition			Prie	uni	me					Onset and De	eath
	/Medical		resulting in death)	Due to	(or as a conse	-+							1 Comme	
	Examiner		Sequentially list conditions,	b								_		
	be isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	equence or):								
	xecut and II-trar	xan	that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):						-		
2/60	eath certificate be executed attending physician and for use as the burial-transit	dical		L.								111		
g	ificate g phy as the	0		u										
nox	h cert andin	M/U	IF FEMALE: 23b. Was decedent pregnant		itcome of pregr		Ectopic pre	nnancy				te of delive		
	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (spec				Mo	onth	Day Ye	Jar
r Ö		Phy	9 ☐ Unknown Part II. Other significant condition				4-4-5		in Donal	22a Did ta	bacco use con	tailer to to the	a anuna at da	ath?
S,	The law requires that the de ate has been signed by the cage 2 should be detached	by	Part II, Other significant conduct	nis contributing to t	eath but not re	salting in the ur	idenying cat	use givei	imranti.	1 🗆 Y	_	3 ☐ Prob		
cords	requ been should	Completed				· · · · · · · · · · · · · · · · · · ·				24a. Was a	(psy findings av	uailabla
ě	sicien: The law certificate has t irector, page 2 s	dw								autop: perfor	med?	prior to cor death?	npletion of cau	use of
Vital		e Co	25. Was case referred to medical						26 Place of Dog	1 ☐ Yes ath (Check only or		1 🗌 Yes	2 No	
	ysicie is cert direct	0 B	examiner?	Hoenital:	Inpatient 2	☐ ER/Outpatien	1 3 DOA	Othor	ч	lome 5 ☐ Resid		ner (Specifi	<i>y</i>)	
0	g Phy er the	—	27. Manner of Death	28a. Date		28b. Time of Injury		c. Injury a	at	28d. Describe h				
0	ath. r: Aft	atio	1 ☐Natural 5 ☐ Pendin 2 ☐ Accident investig	9	iiri, Day 1 oai)	litigaty	М		es 2 No					
DIVISION	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could in determ	ined 288. Plac	e of Injury - At ling, etc. (Spec	home, farm, stre	eet, factory,	office		28f. Location (S City or Tow		er or Rura	l Route Numbe	9 <i>r</i> ,
	ital o													
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier Check only one) Certifyin 2 Medicel	g Physicien: To th Exeminer: On the and mai	e best of my kr pasis of examin nner stated.	nowledge, death nation and/or inv	occurred at restigation, i	t the time n my opii	e, date and place nion, death occu	e, and due to the corred at the time, co	ause(s) and m late and place,	anner as st and due to	ated. the cause(s)	
	To the To the	Me	29b. Signature and title of certifie					License			29d. Date signe			
			> >C) S/	Mund	7			03.	1036		11/37/	2006	,	
	(2)		30. Name and address of person	who completed cau	se of death (Ite	em 23a) (Type,	Print)	1		Lorher	(Mil)	1111		
	Sta	te.	31. Date filed (Month, Day, Year)	32.	Registr s's Sign	nature .	-uvo	h 10	104	311.6	0 01 0	(41)	<u>'</u>	
	Registr		NO	V_3_0 200E	- Alles	man &	Agen	w						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2006 10:25 AM Joseph Shepherd Walker III December /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 330 East Mount Harmony Road Owings Calvert If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 17,1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 81 030-20-0415 Massachusetts Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Calvert Owings 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 20736 330 Mt. Harmony Road, East U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces: 1 Myes 2 □ No If Yes, Give Year or Dates: 1943–45 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M any Injury or other traumatic event, the M onee. engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Shepherd Walker. Theresa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Walker, wife P.O. Box 411, Owings, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12/04/2006 Alexandria, VA 21. Signature of Funeral Service Lib-risee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 locar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: if yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year 4□Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1. Natural 5 Pending Injury 1 □ Yes 2 □ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 033123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

110 Hospital Rd., Suite 310, Prince Frederick, MD 20678

M.D. 110 Hos

4 2006

Jonathan Lowenthal,

DEC

31. Date filed (Month, Day, Year,

			For State Registrar		Sta	ite of M	Marylan		artmen rtificate				lental Hy	giene Reg. No.	2006	40	297
	Physicia	an	1. Decedent's Nam	e (First, Middle	, Last)								2. Date of Dea	Day	Yea	ır	of Death
	/Medic			RTRUDE					41.03	-		-4.50	NOV.	27,	20.0.6	0.82	20. M
	Examin	er	4a. Facility Name (if not institution urban			er)			thes	Location o	of Death		4C.	MONTO	gomery	
	Funeral		5. Social Security N		6. Sex			last birthday)	If Under	1 Year	If Under		8. Date of Birt	h		Birthplace (Sta Country)	
	Director		220-30-	8886	1□ M 3	□ F	95	Yrs.	Months	Days	Hours	Min.	(Month, Da June	y, Year) 15 ,]	911	Maryl	and
_	pu k		Usual Residence of	f Decedent 10b. County			10c Cit	y, Town or Lo	cation					•		10d Inside	City Limits
	Aaryla f sho	٥	MD		tgome	ery			nsin	ator	ı						es 2 ☐ No
	the h	rect	10e. Street and Nu	L					10f. Zip					10g. Citi	zen of What	Country?	
	death with the Maryland ms 23s or 28s-f show Emust be invitibed at	Funeral Director	3901	Hampo	len St	reet	:				208	895			U.S.Z	, A	
	r deal	Iner	11. Marital Status		12. W	as Decede	nt Ever in U	S. 13.	Was Deced f Yes, spec	ent of His	spanic Ori n, Mexicar	gin? (Sp	ecify Yes or No Rican, etc.)		14. Race - Ar Black, W	merican Indian	,
36	s afte	by Fu	1 ☐ Never Marr 3X Widowed	_	ied 1 [∐Yes 2∭x ∕es, Give parorDate:	∑ No		1□Yes 2						Specify:	3lack	
Q Q	tural	edt		15. Deceden	t's Education		s.	16a. Dece	dent's Usua	I Occupa	ition		1	16b. Ki	nd of Busine	ss/Industry	
215	hin 72 en "ne Medili	Completed	(Spec	cify only highe:	st grade com,	oleted) illege (1-4d	or 5+)	(Give	kind of wor DO NOT us	k done d e retired)	luring mos)	t of work	ing				
21,	ad wit	Con	12tl	h				P	ract:	ical					Priva	ate	
Baltimore. Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparminent of Heelith and Mental Hygiene. Department of Heelith and Mental Hygiene. The Medical frame 27 is marked other then "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the invitible at 900ce.	Be	17. Father's Name Unkr		Last)								e (First, Middle, a.G. Bi				
<u> </u>	hould d Mer mark matic	၉	19a. Informant's N		hin /Tune Pr	int)		19h Mailir	a Address	(Street a			al Route Number			Zin Code) o	0070
<u> </u>	od 2 si lith an 27 is r		Briget				ter)						1020,				
9	S 1 ar		20a. Method of Dis	position			20b. F	lace of Dispo	sition (Nan	ne of			Date			or Town, State	
Ê	Page nent o int: If		M□ Burial 2 4 □ Donation	☐ Cremation 5 ☐ Other (S		al from Sta	Fa	irvie	w Cer	n			2/06			ick, M	
alti	permit. Departmine Imports any injuice.		21. Si viatur 11 Fu	neral Service	Ligense	1							OWDEN I				
	20 E # 3	, i	400	11/2	17	no	may	-00					on St, I		ATTTE		
				rtyfailure. List	only one cau	se on each	n line.	4		A .	1	0	or respiratory ar	rest,		Approxir Interval Onset a	nate Between nd Death
j	Physician /Medical		Immediate Cause disease or condition resulting in death)	(fri nai on	- a	+	noiv		may		blt	ca					
	Examiner					Die to (or	as a conseq	uence of):									
		Jer	Faquentially list co if any, leading to in cause. Enter Under Cause (Disease or	mditions, nmediate) "	Due to (or	as a conseq	uence of):								-	
	cuted nd transit	Examiner	that initiated event	5	o:												
2.C.	ate be executed hysician and the burial-transit	I Ex	resulting in death)	Last		Due to (or	as a conseq	uence of):									
% 6820 Box 68760.	physic	Physician/Medical			d												
% 89 X	leath certificate attending phys	/Me	IF FEMALE: 23b. Was deceden	nt pregnant			ne of pregna								23d. Date of	delivery	
S B	0 40 -	Iclar	in the past 12	months?	4[Pregnant	2 Fetal at time of d]Ectopic pro] Other (sp.				<u></u>		Month	Day	Year
100	that the de ed by the detached	hys	9 Unknown		91	Unknown	1										
vi	Se in ed	Ď	Part II. Other signi	ficant conditie	ons contribut	ing to death	n but not res	ulting in the u	nderlying ca	ause give	ın in Part I					to the cause	of death?
	requir been si should	eted													□No 3□		
sectrode i	The law ite has boage 2 st	Completed											24a. Was autop perfo		24b. Were prior t death	autopsy findin to completion o	gs available of cause of
Ž	icien: The lav certificate has ector, page 2	e Co	25. Was case refer	red to medica							on Disease	-4 D1	1□ Yes	2/2 No		es 2□ No	
7 5	Physicien: this certific al director,	To B	examiner?	/	Hospita	al: 1 / Inpa	atient 2	ER/Outpatier	nt 3 DO	A Othe			th <i>Check only</i> o		6 ∏Other (S	pecify)	
Se	ending Physicien: ath. br: After this certific		27. Manner of Dea		288	a. Date of I		28b. Time or		8c. Injury Work			28d. Describe I			,/	
- 0	endir eath. or: Af	catlc	2 Accident	investi 6 ☐ Could	gation				М	1 🗆 1	res 2□	No					
₩ <u>ĕ</u>	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	detem		e. Place of building,	Injury - At he etc. (Specif	ome, farm, str y)	eet, factory	, office			28f. Location (5 City or Tox	Street an vn, State	d Number or)	Rural Route N	lumber,
700	To the Hospital or Attenwithin 24 hours after deatl To the Euneral Director: completely filled in by the	CE	29a. Certifier	1 Certifyir	ng Physician	: To the be	ist of my kno	wledge, deat	n occurred	at the tim	ie, date an	nd place	and due to the	cause(e)	and manner	as stated	
3	S Hou	Medical	(Check only one)	2 Medical	Examiner: C	n the basis	s of examina	tion and/or in	vestigation,	in my op	inion, dea	th occur	red at the time,	date and	place, and d	lue to the caus	e(s)
	To th within To th comp	Me	29b. Signature and	title of certifie	01	/			29c	. License	number	1 Ca		29d. Dat	e signed (Mo	onth, Day, Yea	r)
			> /W	XU)0	n	tel		11	27	06	
	2		30. Name and add	ress of person	who complet	ed cause o	,					D =	J 5	1-	J - **	n 222	7.4
	Sta	te	31. Date filed (Mor	nth, Day, Year)	THE	32 A gi	860 istrar's Signa	iture		get	own	коа	ad, Bet	nes	ua, M	708 חד	14
	Registr			DEC - 1	2006	1000		H No	and a								

		_	For State Registrar	Sta	te of Ma	aryland		artment <i>tificate</i>				lental Hy	giene Reg. No.	006	40298
			Decedent's Name (First, Mid	dle, Last)								2. Date of De	ath	V	3. Time of Death
	Physici		Jack	Į	Veiss							Month Novem	ber 2	2, 200	12:15P ^M
1,000	/Medic	-	4a. Facility Name (If not instituti	on, give street a	nd number)			4b. City, 7	own, or	Location	of Death			County of Dec	
			Shady Grove N	ursing a	and Re	hab			kvil				M	ontgom	
	Funeral Director		5. Social Security Number 088-16-8019	6. Sex 14 M 2			ast birthday) Yrs.	If Under Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 8/21/1	ay, Year)	9. Bi	rthplace (State or Foreign ountry) NY
			Usual Residence of Decedent			7						0/21/1			
	yland how	. [10a. State 10b. Coun	ty		10c. City	, Town or Lo	cation							10d. Inside City Limits 1 XYes 2 No
	e Mai	ctor	MD Mont	gomery		Rocl	kville								
	or 28	Dire	10e. Street and Number					10f. Zip						en of What C	
	ath w	rai	9701 Medical			Constants	C 12	Mac Doord	208		iain2 (Cn	noity Vac or N		ted St	encan Indian,
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28e-f show other traumatic event, the Medical Exercises must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorce	arried 1 [s Decedent ned Forces?]Yes 2 ☐X es, Give ar or Dates:			Yvas Decedi If Yes, spec 1 ☐ Yes 2		Specify:		ecify Yes or No Rican, etc.)		Btack, Whi	
9	2 hou	ted	15. Deced	ent's Education		Ī	16a. Dece	dent's Usua	Occupa	ition	nt of work	ina	16b. Kin	d of Business	s/Industry
21215-0036	within 72 ene. than "n	Completed by	(Specify only high Elementary/Secondary (0-12		leted) lege (1-4or 5	i+)	Econo	kind of wor DO NOT us mict	e reti re d,	uring mos)	st of work	my	IIS	Govern	ment
2	ed wit	Con					псопо								
pu	be file d oth	Be	17. Father's Name (First, Middle									e (First, Middle	, maiden s	sumame)	
Z	12 should be filed within 'n and Mental Hygiene.' 7 is marked other than "reaumatic event, Ina Me.	10	Julius Weiss 19a. Informant's Name/Relatio		ntl		10h Maili	an Address		Faye	_	al Route Numb	er City or	Town State	Zin Code)
Maryland	nd 2 st lith and Lith and 27 is r		Joel Weiss -		10)			•				nt MD 2		7 0 11 17	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		20a. Method of Disposition 1 ↑ Burial 2 □ Crematio ↑ 4 □ Donation 5 □ Other		I from State	C	lace of Dispo emetery, crea	natory`or ot	her place	1		Date 24/06		ation - City o	r Town, State
3altir	permit. P Departme Importen any injur		21. Signature of Funeral Service			, June 1		-				al Dire			
	Physician		23a. Part 1. Enter the disease, shock, or heart failure. L	or complications ist only one caus	e on each li	ne.	n. Do not en ac Arr	ter the mode	of dying	ile] g, such as	Pike cardiac	Rockvi or respiratory a	11e M arrest,	D 2085	Approximate Interval Between Onset and Death instant
	/Medical Examiner		disease or condition resulting in death)	a	Oue to (or as		uence of): ary Ar	terv :	Dise	ase					years
	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as										
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Oue to (or as	a consequ	uence of):								
8760,	# × #	lical		d				····							
P.O. Box 6	death e atter d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	10	es, outcome]Live birth]Pregnant a]Unknown	2 Fetal	Ideath 3	⊒Ectopic pro ⊒ Other <i>(sp</i> o					2:	3d. Date of de Month	elivery Day Year
	es tha	ρ	Part II. Other significant cond Dementia		ng to death b	out not resi	ulting in the t	inderlying ca	ause give	en in Part	l.	1 444	tobacco us Yes 2K		to the cause of death? Probably 4 □Unknown
Division of Vital Records,	e c e	Completed	Hyperter	sion								24a. Wa: auto perf 1 ☐ Yes	opsy ormed?	24b. Were a prior to death?	autopsy findings available completion of cause of
ita	ician: Th certificate rector, pag	Be C	25. Was case referred to med examiner?	ical						26. Plac	e of Deat	h (Check only			
>	nysic nis ce I direc	To	1 ☐ Yes 2 ☐XNo	Hospita	1 U Inpati		ER/Outpatie		-	4 A IN	ursing Ho	ome 5□Res			ecify)
0	ding Ph J. After th funeral		27. Manner of Death 1 Natural 5 □ Per		. Date of Inju (Month, Da	iry iy Year)	28b. Time of Injury		8c. Injun Worl		, I	28d. Describe	how injury	occurred	
)ivisio		Certification:	3 ☐ Suicide 6 ☐ Cou	ostigation ald not be emined 28e	. Ptace of In building, e	jury - At ho tc. <i>(Specif</i>)	ome, farm, st	M reet, factory		Yes 2□	140		(Street and own, State)	l Number or F	Rural Route Number,
J	Hospita 4 hours Funerel ely fillec	Medical Ce				of examina									as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of cert	ifier					8656	e number					2, 2006
	10		30.4 mm and address of pers Ravi Passi MI						ockv	ille	MD	20850			
	St Regist	ate rar	31. Date filed (Month, Day, Ye		32. Begist	rar's Signa									
					The state of the s	-									

ORIGINAL

DHMH 17 Rev 1/2001

			1- For State of Maryland / Dep Ce	artment of Health and M rtificate of Death		ene 006 40299
	Dhusisi	4	Decedent's Name (First, Middle, Last)		2. Date of Death	
J.	Physici /Medio		Ruth Virginia Yingling		Month 12	1 2006 9:20 P M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. Cily, Town, or Location of Death		4c. County of Death
			Golden Crest Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hampstead If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carroll
	Funeral Director		216-09-7117 1□M 2∰F 96 Yrs.	Months Days Hours Min.	(Month, Day, 06/07/	Year) 9. Birthplace (State or Foreign Country) 1910 MD
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	B Ma	ctor	MD Carroll Hampste	ad		1 ☐ Yes 2∰ No
	th with th	Funeral Director	912 Clearview Ave.	10f. Zip Code 21074	10	g. Citizen of What Country? USA
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinant Trausl Den Lillied at Once.	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 4 Divorced 1 Never Married 4 Divorced 1 Narried 5 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: White
21215-0036	hin 72 hou B. An "natura Magical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of workir DO NOT use retired)	ng 1	6b. Kind of Business/Industry
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nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	aiden Sumame)
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Maryland	12 sh h and r is m		II I I I I I I I I I I I I I I I I I I	ng Address (Street and Number or Rura		
	1 and Health em 2 ther 1		The state of the s	Charmil Dr. Ma		er MD 21102 Oc. Location - City or Town, State
Ď	ages nt of 1 t: if it		Tap bullar 2 Cremation 3 Hamoval non State	matory`or other place)	-	Manchester, MD
Baltimore,	artme ortani injury					eral Home
Ba	Depa Impo any is			934 South Main S		
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a prequence of):	ter the mode of dying, such as cardiac o Caranoma of	the 1	st, Approximate Interval Batween Onset and Death Tyuars
3760,	cate be executed physician and ithe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):			
.O. Box 6	law requires that the death certificate be executed as been signed by the ettending physician and 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that in signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the t	inderlying cause given in Part I.		accoluse contribute to the cause of death?
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of	ding Phy I. After this funeral d	tion; To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		ne 5 Residen 8d. Describe how	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	the Hospital hin 24 hours a the Funeral I npletely filled	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Certifying Physician: To the best of my knowledge, deal (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the cau id at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
)	WIT		flequeria U. Jaestin pue	1/2001	1	2/4/06
	W5		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	01 1	6 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Sta	te	31. De filed (Month, Day, Year) 32. Regignar's Signature	ver beckleysville	Ka. Ho	empstead. MD 21074
	Registr		DEC 0 4 2006 Keeper &	Snack,		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 1, 2006 2:45P. M Joseph J. Zajicek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care & Rehab. Center Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov. 18, 1925 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months New York 1 M 2 □ F 068-18-9466 81 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits Show ith and Mental Hygiene. 27 is marked other then "neturel", or items 23s or 28s-1 show traumatic event, its Medical Examinar must be notified at 1 XYes 2 No Directo Frederick Frederick Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 343 A Field Point Blvd. Apt 204 21701 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Furniture Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zajicek Joseph J. Mary Stupavsky ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joanne Balderson/Daughter 10702 Etzler Mill Road, Woodsboro, MD 21798 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Incremation 3 ☐ Removal from State 12/5/2006 Frederick Crematory Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ${\bf Stauffer}$ Funeral ${\bf Home}$, ${\bf PA}$ 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** as cenoma /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Certification; To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1□ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No ierei Director: After th 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending efter death investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours efter or To the Funerel Direct 4 T Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d couse of death (Item 23a) (Type, Print) Robert L. Kaufmann Frederick,MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 5 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 9, 2006 **Physician** 2:49 AM M Evelyn Marie Zavona /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year)
March 16, 1918 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2√X Maryland 578-26-4297 88 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with is not of Health and Mental Hygiene. Int: If Item 27 is marked other then "neturel; or Iteme 23a or; 20902 U.S.A. 10703 Malone Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z Z No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: White Baltimore, Maryland 21215-0036 Specify: δ 3XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John E. Stone Flora Castle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Lee, son 10703 Malone Street, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny injury or 2002. St. Lukes Cemetery Dec. 16, 2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liçensee ²² Name and Address of Basford PA Funeral Home RichardE MOO255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 24 Hrs. **Physician** Cardiogenic Shock /Medical Due to (or as a consequence of) Examiner Intralateral Myocardial Infaction 36 Hrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires thet the death certificate be executed physicien and s the burial-trans Coronary Artery Disease Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be c Meserteric Ischemia 1 Yes 2 No 3 Probably 4XX nknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2XXNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ vo Necrotic Bowel page 2 s certificete 2**X**X/o To the Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ŽXNo Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical WAR 29c. License number 36822 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ON JANNO GRONGER /(100 POLEN) GEN NO & LOO, SICUEN NALING NES

31. Date filed (Month Comments) 32. Pegistrar's Signature DEC 1 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Marissa Marie Barr	1-	S For State gistrar	tate of Ma	ryland		ment of F ficate of D		nd Men	tal Hygi		g. N o	200	6 4030
Physician/ Medical Examine	1.	Decedent's Name (First, Mid Mariss		Barr	ier					Date of Death Month December		Year	3. Time of Death 1155 hrs
		a. Facility Name (if not institut	ion, give street ar				City, Town, o	r Location o		recember	4c. C	ounty of Deat	
	5	Laurel Regional Hos Social Security Number	pital 6. Sex	Ι 7 Δα	ge (In yrs. last		.aurel If Under 1 Yea	ar If Unde	er 24Hrs 8.	Date of Birt		rce George	e's rthplace (State or
Funeral Director	L	219-75-7862	1 M 2 X		ge (III yrs. Iast	_	Months Day			07/20/		Foreig	
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th the Maryland 23a or 28a-f sh notified at once			ley Place				Of. Zip Code	20707				of What Cou USA	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event. the Medical Examiner must be notified at once. To Be Completed by Funeral Director			Married Arm	ed Forces' 'es 2	t Ever in U.S. ? No	If Yes,	ecedent of H specify Cuba	ın, Mexican	, Puerto Rica			White, etc.	acan Indian, Black,
ours aft atural" samine	`⊢	15. Decedent's Education (Sp	or Dates:		mpleted) 16	6a. Decedent's	Usual Occupa	ation (Give	kind of work	done		of Business/	
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21215-0036 build be filed within 7 Mental Hygiene, marked other than e event. the Medica TO Be Comple	L			rier						Brandi		veless	
MD 21 nd 2 should alth and Me m 27 is ma raumatic er	19	a. Informant's Name/Relation Ma		rier		19b. Mailing Ad			nber or Rurai y Place			or Town, State MD 207	
e, W		Da. Method of Disposition				ce of Dispositio	n (Name of ce			ete		ation - City or	
Baltimore, permit Pages I an Department of Her Important: If ite		Burial 2 Cremation Donation 5 Other		val from St	ale	awn Memor		·k	12/18	/2006	Ro	ockville	. MD
Balti permit Departin Import	2	Signature of Funeral Service	e Licensee				e and Addres	-	у				
Physician		Shawn E. Wells (p. Ba Part I. Enter the disease, c	or complications t	hat caused	the death. De	not enter the	ck Fune mode of dying	ra I Hor , such as c	me, Inc ardiac or res	 7601 spiratory arre 	Sandy st, shock,	Spring or heart	Rd., Laurel, MD Approximate Interval
/Medical xaminer		failure List only one caus nmediate Cause (Final diseas r condition resulting in death)	e a Stre		CUS DICU equence of):	moria sep	s S						Between Onset and Death
ted Insit Examiner	S if c:	equentially list conditions, any, leading to immediate ause. Enter Underlying Caus bisease or mjory that initiated	е с		sequence of):								
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687 certifica nding p use as th	23	FEMALE: b. Was decedent pregnant in past 12 months? Yes 2 No 9 U	the 1 L	yes, outco .ive birth	me of pregnar	2 Fetal			c pregnancy		200	ate of deliver onth	y Day Year
— 5 5 6 — —		art II. Other significant cond	litions contribut	ing to deat	th but not resu	liting in the und	erlying cause	given in Pa	art I				the cause of death?
ords, P.C. v requires that s been signed is should be deta							 		- 1	1Yes 24a. Was a	2 🗸 N		bably 4 Unknown utopsy findings available
Records, P.O. Box The law requires that the death ficate has been signed by the atte t page 2 should be detached for u Completed by Physic										autops perform 1 V Yes 2	ned?	prior to death?	completion of cause of
Vital Relativisticians: The Idirector, page	2	5. Was case referred to medic examiner?	Hospital:	Innati	ent 2 El	R/Outpatient 3		of Death	(Check only Nursing Ho		Posidone	e 6 🗸 Othe	r Saana
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Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: Aft completely filled in by the fune edical Certification:		Suicide 6 Co	uld not be	Place of In	njury - At hom	e, farm, street, f	actory, office	building, et	tc 28f	Location (S or Town, St		Number or Ru	ural Route Number, City
To the Hosp within 24 hos To the Fune completely fill Medical C		oncon only	Physician: To the taminer: On the band man		-								
FIFT	2	9b Signature and title of certi	fier ¢				29c. Licen	se number	- ·			e signed (Mo	onth, Day, Year)
	3). Name and address of person					.l.						
	2	Ana Rubio MD. As	ssistant Medi		niner 11 ar's Signature	1 Penn Stre	eet, Baltim	pre, MD	21201				
State Registra	×	DEC 1		Line	a. o Signature	Local							
DHMH 17 Rev 1/2001						ORIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Month Decarbo 1524 Val Ronald Coleman Brecher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bartonine - Cell Hory tow fled cont Tr Under 1 Year | If Anunder 8. Date of Birth JUL 16, 1945 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral 1√∑** M 2 □ F 231-58-6569 Texas Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Anne Arundel Odenton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2006 Kintore Circle Apt 104 21113 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Folces: 1 XYes 2 No If Yes, Give Year or DatesVietnam 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Worker Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Brecher Dorothy Davis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>(1)</u> Health tem 27 Fave Brecher/Wife 2006 Kintore Circle Apt 104 Odenton, MD 21113 20a. Method of Disposition 20c. Location - City or Town, State Important: If It any Injury or o once, 1 Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 12/18/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Todd Dring 299 Frederick RD Baltimore MD 21228 23a. Part1. Enter the disease, or completion, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leading to the content of Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sevene ANOXICE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sugarho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) December 15 1 2001

Registrar
DHMH 17 Rev 1/2001

State

Glan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

neve

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DECEMBER Day **Physician** 3.09 PM 17 2006 Brown Rena /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OF BALTIMORE SINAL HOSPITAL If Under 1 Year Baltimore 11 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours 1 □ M 2 □ F 148-14-4910 91 02/01/1915 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1√2 Yes 2 □ No Directo Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4017 Liberty Heights Avenue 14. Race - American Indian, Black, White, etc. Funeral 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Marned Blac k 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hester Daniels James Clayton Gregory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3911 W. Garrison Ave., Baltimore, Maryland 21215 Willie Bryan / Sister
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2006 Landsdowne, Maryland Mt. Zion Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service, Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEVMONIA disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (u. as a consequence of) Examiner CONGELTUE HEART Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIABETES MELLITUS 1 Yes 2000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an DEMENTIA autopsy performed' 2 No 1 Yes No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

burial-transit The law requires that the death certificate be executed and Box 68760 the attending physician use as the P.O. I Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeraf Director: A completely filled in by the fu

Funeral

Director

ral", or Items 23a or 28a-f show Examiner roust be notified at

"natural",

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "naturany injury or other traumatic event, the Medical I

Physician

Examiner

/Medical

the Maryland

72 hours after

altimore, Maryland 21215-0036

AMAN SIDAL, MD. 31. Date filed (Month, Day, Year) Registrar

SINAL HOSPITAL OF BACTIMORE, 2401 WEST BULLEDERE AUE. BACTIMORE MI) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO06 1959

DECEMBER 17, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 15 WYGCSS 15,2006 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner War Drive ntur neorges Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 6. Sex If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign , Country) **Funeral** 231-68-60' Months Days Hours Min 1 M 2 □ F Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be matriced at 1 ☐ Yes 2 No Director inaton 10e. Street and Number Jof. Zip Code 10g. Citizen of What Country? 3406 206 SA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Byes 2 No If Yes, Give Year or Dates: 1972-1992 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If item 27 is marked ot racss camo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 Removal from State National Geneka viantics ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of dicility any ir Service 2605 S. Shirlingtonkel. Arlington bezzug 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 16US100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a lonsequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed a a onsequen e of): Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Donknown 1 🗌 Yes 2 🗌 No 3 Probably Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy certificate 2 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 AOther (Specify) Hospital: Other: P 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this Director: After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Thomicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 5286 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Nisconsin State DEC 1 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2006 28 1:25a Nov. CHARLIE THEOTIS BRANCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital 01ney 8. Date of Birth (Month, Day, Year) 1922 Surrenton, NC If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□ F Months Days Hours 84 Director 232-30-4342 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County r then "natural", or items 23s or 28e-1 ehow the Medical Examiner must be notified at tx Yes 2 No Director Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3330 Leisure World Blvd. #121 Bld 5 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Animal Research Analyst other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie marked of Pages 1 and 2 should be Fred D. Branch Willie B. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 Leisure World Blvd. #121 Bldg 5 Silver Spring, Md. 20910 19a. Informant's Name/Relationship (Type, Print) if item 27 i Betty Branch/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if eny injury or once. 12/2/2006 Adelphi, Md. George Washington 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Marshall s Funeral Home, Inc. 4217 9th St. N.W. Washington, DC 20011 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOIMM /Medical Examiner Sequentially list conditions, Due to (ut as a consequence oi). n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached for a□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has b irector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No : After this certific e funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director; 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a

To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 15/06 D0063196 repleted cause of death (Item 23a) (Type, Print)

Wew 18101 Prince Pulip Drive 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Marie Louise Burton December 15 2006 6:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson If Under 24 Hrs. 8. Date of 8irth 5. Social Security Number 212–32–2317 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) **Funeral** 1□ M 2☑ F Months Hours Min. 87 Yrs. September 12, 1919 Baltimore, MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f shov ury or other traumatic event, I'ra Medical Exercited reset to itelifical at MD Baltimore White Hall 1 Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20628 W. Liberty Road 21161 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Park W. Allender Unknown Known ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Burton-Son 20628 W. Liberty Road White Hall, Maryland 21161 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Evans Funeral Chapel—Belair permit. Page Department of Important: If any injury or Forest Hill, Maryland 4 ☐ Donation ,5 ☐ Other (Specify) 21. Signal of uneral Service License Peacefal Alternatives Funeral and Cremation Center 2325 York Road Timonium, Maryland 21093 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Setween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□ Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Day Year 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by oneumonia 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes 2□ No funeral director. 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Naturat 2 Accident 5 Pendina thours after death.

uneral Director: Af 1 □ Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 19

2006

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Bailer Elease /Medical amber 2006 4b. City, Town, or Location of Death 4c. County of Death Examiner Simai Baltimore CITY If Under 1 Year | If Under 24 H/s. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2\ F Days 219-38-3928 Feb 4, 1940 Director 66 Usual Residence of Decede 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Md Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avalor 2310 USA Funeral 21217 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Yes 2 N If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12+~ 00 K UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ္ 19a. Informant's Name/Relationship (Type. Print) Lynn Bailey Fremont Ave Baltimore 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 DRemoval from State 4 Donation 5 Dother (Specify) Woodlawn Cemetery 12/21/06 Woodlawn Md. 21. Signature of Funeral Service Licensee 22. Name and Address on Facility Chatman - Harris Funcal Home every ans 5240 Reisters town Rd Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** verwhelmin days /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): A pue death certificate be executed burial-transit Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy performe funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 11 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation Natural Injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 (1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

MD

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32. Registrar's Signature

Balhmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 12, Month **Physician** 2006 Charles Allen Brunner December /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Jun. 16, 1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑** M 2□ F 212-42-1977 63 Jun. Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f sh notified 1 ☐Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 1224 Washington Blvd. 21230 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1⊕ Yes 2 □ No IlYes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 √ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates: White 'natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Electrical Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Hamilton Francis Brunner Ida C. Perigot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) f Health item 27 i Mary B. Stinchcomb - Sister 1224 Washington Blvd., Baltimore, MD 21230 other 20b. Place of Disposition (Name of corretery, crematory or other place)
West Arundel 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Pages
Department of Important: If its
any injury or o 12-18-2006 Odenton, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc Signature of Furiera Service Licenses 2719 Hammonds Fry Rd., Lansdogne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2**X** No 1 ☐ Yes 2☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 📉 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) n. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10:30 р.ш.

2006

DECEMBER

CHARLES BRUNNER

State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.



DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

			For State Registrar		State o	i Marylan		artment of H tificate of l		d Mental i	Hygie Reg.	$Z \coprod \coprod$	6	40310	
Ė	Physicia	an	1. Decedent's Name (First,							2. Date o Month		Day	Year	3. Time of Death	_
A.	/Medic Examin	al .	Helen Wilma 4a. Facility Name (If not inst			mber)		4b. City, Town, or	Location of D	Decen eath	ber	Day 15, 20 4c. County		2:50 A M	
	LXaiiiii	C1	Catonsville					Catonsvi	lle			Baltir	nore		
i de la constante de la consta	Funeral Director		5. Social Security Number 217–20–1383		ex □M 2[X]F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Ain. (Month	, Day, Ye	1926	9. Birthpl Count Ohio	ace (State or Foreign try))	,
	/land ow		Usual Residence of Decede 10a. State 10b. Co			10c. City	y, Town or Lo	cation					10	Od. Inside City Limits	_
	a-f sh	ctor	MD Bal	timor	e	Lan	sdowne	2						1 □Yes 2 No	
	or 28	Dire	10e. Street and Number	Г.	D 1			10f. Zip Code				Citizen of W	/hat Coun	try?	
	leath v	Funeral Director	4135 Hollins	rerr		edent Ever in U.	S. 13. ¹	21227	ispanic Origin	? (Specify Yes o		S.A. 14. Race	- America	an Indian.	_
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Never Married 2		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	orces? 2 ሺ No ve		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	uerto Rican, etc.)	Black	k, White, o	etc.	
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ylar	ould by Menta arked attle evaluation	To	William Edwa:							Smith					
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Rela		ype. Print)			ng Address (Street				-		Code)	
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Baltimore, Maryland 21215-0036	t. Page rtment o rtant: If		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott	ner (<i>Specif</i> y	2	State Lou		rk Cemete	-	-18-200			•	Maryland	
Bal	Depa Impo any I	2.5	21. Si nature of Funeral So	le Z	· Bally	checks	$egin{array}{c} \hat{ ext{A}} \ 1 \end{array}$	Name and Address Mbrose Fu 328 Sulph	ineral ur Spr	Home, Ing Rd.	nc. Arbi	utus M	D 212	227	
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	To the Nathin 24	Me	29b. Signature and title of	ertifer	l			29c. Licens	e number	- /	29d.	Date signed	(Month, I	Day, Year)	
	V		30. Name and address of p	erson who	completed cause	se of death (Item	n 23a) (Type,	Print) Lite	130 Cm	froulle	\	5 767	228		_
	Sta	te.	31. Date filed (Month, Day,			Registrar's Signa		- de le							_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For Stete Registre Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Day Year December 15, 2006 **Physician** Virgie Irene Beck 1:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Havre de Grace Harford Harford Memorial Hospital | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Ye July 4, 1 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□¥ 92 Director 216-12-6897 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Maryland Edgewood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21040 3914 Love Ave. USA 238 Funera 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Specify: þ 3 ₩idowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other then College (1-4or 5+) Hygiene. Twister Hand Cotton Mill 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked o Ida Mae Botterill James Rayburn Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
important: if item 27 ie
eny injury or other trat
once. 3914 Love Ave., Edgewood, Maryland 21040 Albert Bair / Grandson-Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12-19-06 Bel Air Memorial Bel Air, Maryland 4 ☐Donation 5 ☐ Other (Specify) 21. Si McComas Funeral Home, P. A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by t rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy perform 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 1 ☐ Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. 1 Tes 2 No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Sunds

Registrar

State

30. Name and address of person who

9 2006

HOMAS

31. Date filed (Month, Day, Year)

rene

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

BIONIO

06-09596 Frank Ivory Battle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Tall	K IVOIY Datti		1- For State Certificate of Death Registrar	na mentai riygi	Reg	No. 2006	5 40312
	Physicia	in/	1. Decedent's Name (First, Middle, Last)	2. [Date of Death Month Da December 16	ay Year	3. Time of Death 0627 hrs
wec	lical Exami		FRANK IVORY BATTLE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, in the control of the cont	or Location of Death	ecember 16	4c. County of Death	
			6609 Sanzo Road, Apt. E Pikesville			Baltimore Cou	ınty
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye		. Date of Birth (MM/DD/YYYY) 9. Bir	
	Director	į	240-21 3545 1X M 2 F 41 Yrs. Months Da	ays Hours Min.	SEPT.4	,1965 ^{co}	WASHINGTON DC
	ıy.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			-	10d. Inside City Limits
	1 10 w ar		MD. BALTIMORE PIKESVIL	LE			1 X Yes 2 No
	arylan 8a-f sl at onc	Director	10e. Street and Number 10f. Zip Code	?	10g.	Citizen of What Cou	ntry?
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		6609 SANZO ROAD APT.E 2120	9		USA	
	h with ems 2.	Funeral		Hispanic Origin? (Specifoan, Mexican, Puerto Rica		14. Race - Amer White, etc.	ican Indian, 8lack,
	er deat , or it	필	Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No	No specify:		Specify: D.F.	n GV
	urs aft tural" amine	<u>Ş</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occur	pation (Give kind of work		Specify: BLA Sb. Kind of Business/	
	72 hor n "na	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working li	ife. DO NOT use retired)			
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	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) ERNEST WILLIAMS	ERMA BA'		den Surname)	
	212 ould be Ments mark c even	은 은	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str			r, City or Town, State	e, Zip Code)
	MD 2 sho alth and m 27 is			ZO RD. AP'	T.E PI	KESVILLE	E,MD.
	S land of Heal		20a Method of Disposition 1 X Byrial 2 Cremation 3 X Removal from State 20b. Place of Disposition (Name of Corematory or other place)			Oc. Location - City or	<i>'</i>
	Baltimore, Department of He important: If ite		4 Ponation 5 Other Specify: BATTLE BORO C		23,200	6 WHITAK	KER, N.C.
	Ball permit Depart Impor		2 Strature of Funeral Service Licensee 22. Name and Addre CALVIN	B. SCRUGG:	S FUNE	RAL HOME	E
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	/Medical	5 5	failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (heroin) and alcohol int				Between Onset and Death
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	760, cate be ex physician the burial		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
	ox 687 eath certific : attending	/sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify)	3 Ectopic pregnancy		Month	Day Year
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	ords, P.O. Box 68' w requires that the death certiff is been signed by the attending should be detached for use as	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.		cco use contribute to	
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	Rec The I ficate b	Cour			1 Y Yes 2	No 1 ✓ Y	es 2 No
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	Division of Vital Records, P.O ral or attending Physician: The law requires that t is after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	.: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Ir			v injury occurred	
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	ivision or Attendate death Director:	ifica	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office		f. Location (Stre	et and Number or Ri e) 6609 Sanzo	ural Route Number, City
	Djvi spital or hours afte neral Dir filled in	Cerl	4 Homicide determined (Specify) House 29a. Certifier 1 Certifier Physician Te the best of my knowledge, death occurred at the time.		<u>Ikesville</u>	e. MD	
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	To To	Med	and manner stated. 29b. Signature and title of certifier 29c. Lice	ense number	2	9d. Date signed (Mo	onth, Day, Year)
			Parasto Frank will MD	C.M.E.	[December 17, 2	006
	/		30. Name and address of person who completed cause of death (Item 23a)				
	γ			eet, Baltimore, MD 	21201		
	S Regis	tate trar					
	1.091						

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

600 N. WOLRST

32. Registrar's Signature

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 17, 2006 6:00 A December Aleksandr Sviridovigh Chikerenda 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore 9520 Perry Hall Blvd. Apt 204 Nottingham 8. Date of Birth (Month, Day, Year) April 27, 1939 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex Months 1 M 2 □ F Ukraine 214-59-1428 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No Nottingham Baltimore Maruland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Ukraine 21236 9520 Perry Hall Blvd. Apt 204 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Palageya Svirid Chikerenop 19a. Informant's Name/Relationship (Type, Print) (Dahtr) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Barkeford Road, Bel Air, Maryland 21014 Lidiya Aleksandrovna Petruk 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gardens 12/20/2006 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Nottingham, Maryland 21236 Stepanio < unek 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Massive Corebbal Theombosis-Immediate Cause (Final disease or condition resulting in death) elecolu Here to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last remenve he ary reiseon IF FEMALE: 23c. If yes, outcome of pregnancy
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Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use es the burial-transit Box 68760. Division of Vital Records, P.O. s been signed by the or Attending Physician: After this within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu To the Hospitel

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Hygiene.

Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, and once.

Pnysician /Medical

Peges 1 and 2 should

Direct

Funeral

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Completed

Be

Examiner

Physician/Medical

the Maryland

Baltimore, Maryland 21215-0036

State

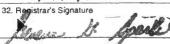
Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Y.K. RAMATAHIMD, 447 Kenwood. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

Medical



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

		-	State State Registrar	of Maryland	l / Depa <i>Cer</i>	artment of He rtificate of E	ealth and N Death		giene leg. No.2006	40315
			Decedent's Name (First, Middle, Last)	 				2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Joan H. Cox					Decembe		6:03 P M
	Examin	_	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or			4c. County of Dea	
	Note that the same of the same		Stella Maris Hospice	7 4 - // //-	a a la inale elecció	If Under 1 Year	ONLUM If Under 24 Hrs.	9 Date of Birth		timore
Е	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la:	St birthday). Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day June 2,	1932 Wes	thplace (State or Foreign ountry) t Virginia
6	Director	}	218-26-7343 Usual Residence of Decedent	14				June 2,	1932 Wes	a vargana
	yland yland yland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-f st	ctor	Maryland Baltimo	re		Perry Ha	ll			1 □Yes 2X No
	or 28)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at	Funeral Director	8648 Castlemill Circl				236		u.s.	
	items	ane	Arme	Decedent Ever in U.S. d Forces? es 2 🕱 No	. 13.	Was Decedent of His f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	rs aft	by F	if Yes	es 2 (A) NO , Give or Dates:		1 □ Yes 2 🛱 No	Specify:		Specify: (Ihite
21215-0036	atura	ed	15. Decedent's Education		16a. Deced	dent's Usual Occupa	ition		16b. Kind of Business	/Industry
215	nin 7% In "ni Medi	Completed	(Specify only highest grade comple Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	(Give lite. L	kind of work done d DO NOT use retired;	uring most of worl	king		
212	d with	ĕ	10th Grade	, , , , ,		Homemake		:	Own Hon	16
	al Hy d other	Be (17. Father's Name (First, Middle, Last)						Maiden Surname)	
yla	ould k Ment arked aric e	၉	Unknown					Harman		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Men		19a. Informant's Name/Relationship (Type. Print)			-			r, City or Town, State,	•
	and tealt		Reba Eckenrode (daugh		8648	sition (Name of	u circi	e, revii	HALL, MAY 20c. Location - City of	yland 21236
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item any Injury or othe once.		1 ☐ Burial 2 X Cremation 3 ☐ Removal f	rom State CO	metery, crer	natory or other place Crematori	9) ;		Baltimore,	
ij	iit. Partme		4 □ Donation 5 □ Other (Specify) 21. (Signature of Fundal Service Licentee	ba	_				Funeral Ho	
Ва	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		Som Comainty.		9	705 Belai	r Road,	Baltimor	ie, Marylar	nd 21236
			2 a Part Enter the disease, or complications t	nat caused the death. on each line.	Do not ent	er the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
1	Physician		rediate Cause (Final disease or condition a PAI	KINSON'S	DISEAS	SE				Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a conseque	ence of):	010				
	LAdillilei	L.	Sequentially list conditions, b.	e to (or as a conseque	ance of):					
1	ped sit	nje.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a conseque	erice or).					
V	xecul and	Examiner	that initiated events c	e to (or as a conseque	ence of):					
8760,	icate be executed physician and the burial-transit	dical E	d							
89		edi								
Вох	death certifica e attending pl d for use as t	Physician/Me	23b. was decedent pregnant	, outcome pf pregnan ive birth 2 ☐ Fetal		∃Ectopic pregnancy			23d. Date of de	
		sicis	1 Yes 2 No	regnant at time of de		Other (specify)			Month	Day Year
P.0	requires that the een signed by th hould be detache	Phys	9 Li Unknown		tring of the state	-1-1-1	- i- D-41	and Did to		- Marana at death 0
	res th igned	by	Part II. Other significant conditions contributing	to death but not resul	iting in the u	ndenying cause give	en in Part I.		obacco use contribute f ′es 2 □ No 3 □ F	
oro	w require been si	ted								. A
Records,	e 2 sh	Completed						24a. Was autop		utopsy findings available completion of cause of
alF	r: The licate ha							1□ Yes	2 No 1 □ Ye	
Vital	Physician: The law this certificate has I al director, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	4.53		Othe	26. Place of Dea			
0	<u>a</u> = <u>e</u>	년 ::	1 ☐ Yes 2 No 1103pttal. 28a. I	Date of Injury	R/Outpatier 28b. Time o	IL 3 L DOA	4 ☐ Nursing H		lence 6 Other (Sp.	ecify) HOSPICE
Division	Attending Phyrdeath. ector: After thi	tio	1 Natural 5 ☐ Pending investigation	Month, Day Year)	Injury		ć? Yes 2 □ No			
Visi	or Attendater death Director:	iţica	3 Suicide 6 Could not be 28e. I	Place of injury - At hor building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (S City or Tow	Street and Number or F	Rural Route Number,
ā	s afte	Certification:	4 Nothidae	dilding, etc. (Specify)	,			City of You	ni, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Medical (29a. Certifier (Check only one) 1X Certifying Physician: T 2							
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	mamor states.		29c. License	e number		29d. Date signed (Mor	nth, Day, Year)
	FSFÖ		1			Do	13725		12/18/	06
			30. Name and address of person who completed	cause of death (item	23a) (Type,		, , , , , ,		11/	
	3			00 DULANE			IMONIUM,	MD 210	93	
	St	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Signat	ure	0				
	Regist	rar	DEC 1 9 2006	Blogues L	K A	300 15 5				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17, 2006 Albert Howard Cyford 9:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Min. | JUL 18, 1 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 1950 56 217-54-7911 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic and any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 √Yes 2 No Completed by Funeral Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1307 Argonne Drive 21218 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Caterer Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard C. Cyford Lillian E. Wyant ၀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Cyford/Wife 1307 Argonne Drive Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc 12/18/06 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee C. Todd Dring C. Tild 299 Frederick Rd Baltimore, MD 21228 that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Dulmmi Physician months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □ Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) WOSPLE 1 ☐ Yes 🍇 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation Injury Natural 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 18 2006

State Registrar

0

MARIA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

6565 N. Charles ST

Browns NO 21204

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

WO

32 Registrar's Signature

J. CHARLUES

			1 - For State Registrar		Marylan		artment o				eg. No.	006	40	317
	Physici /Medio		Decedent's Name (First, Middle KAMERON LESL	. ,						2. Date of Dear Month DECEME	Day	1, 200		of Death
f 	Examir		4a. Facility Name (If not institution Sinai Hospit	al of Ba	Him		4b. City, Tow Balt	mor	on of Death		4c. C	N/A		
	Funeral Director		5. Social Security Number UNL Usual Residence of Decedent	6. Sex 7.	Age (In yrs. I	O Yrs.	400	ays Hou		8. Date of Birth (Month, Day, DECEMA			inthplace (State Country) Mur	yla-nd
	death with the Maryland ms 23a or 28a-f ehow Emust be notillied at	ector	MD • 10b. County	1		ALTIMO	DRE							City Limits es 2 ☐ No
	leath with t ns 23a or 2 must be n	Funeral Director	10e. Street and Number 3224 AVONDALI	12. Was Decede	nt Ever in U.	S. 13.1		215	Origin? (Spe		US		ountry?	
2-0036	72 hours after or natural', or Iter	þ	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Force	s? X ^{No}	i	f Yes, specify (1 ☐ Yes 2 🔀			cify Yes or No- Rican, etc.)		Black, Wh		
1215-	within ene. then "	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4c	or 5+)	(Give life. l	dent's Usual Oc kind of work do DO NOT use re INFANT	ne during n	nost of worki	ng	16b. Kind	d of Busines	s/Industry	
Jana 2	be filed tal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, EMMANUEL COUR							(First, Middle, /		'umame)		
, mary	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relations			322	4 AVON	DALE I	BALTIM	Route Number				
TIMORE	permit. Pages 1 al Depertment of Hea Important: if Item eny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 M Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	MET	RO CRE	sition (Name o natory or other EMATORY		12-15	-2006	ALTI	MORE.	r Town, State	AND
ga	permit Deper Impor eny in		21. Signature of durral Sevice 23a. Part1. Phter the disease, or	complications that caus	ed the death	1	721-27	N. MO	ONROE S	LLIPS FU	IMOF		RYLAND	21217 ate
,	Physician /Medical		shock of r heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	line.								Interval B Onset and 5 hrs	atween Death 4) min
	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. RESDI Due to (or Due to (or	as a consequ			sia					11	'/
3/00,	ate be executed thysicien and the burial-transit	icai Examiner	that initiated events resulting in death) Last	c. Due to (or d.	as a con sou		5 : 5							
O. Box 68	auth certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Fetal at time of de	death 3	Ectopic pregna Other (specify				23	d. Date of de Month	alivery Day	Year
rds, P.	requires that the de been signed by the should be detached	þ	Part II. Other significant condition	ns contributing to death	but not resu	Iting in the ur	nderlying cause	given in Pa	nrt I.	23e. Did tob	1	/	to the cause of	
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<u> </u>	Physicien: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ıtient 2□E	ER/Outpatien	t 3 DOA	Othor		Check only on	-	704 (0		
VISION OF	문 문 표		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of In (Month, I		28b. Time of Injury	28c. I	njury at Work? 1 🗆 Yes 2	2	ne 5 Reside 18d. Describe ho			эспу)	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 288. Place of building,	etc. (Specify)	eet, factory, off			8f. Location (St. City or Town	, State)			mber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 2 Medical one)	g Physician: To the be Examiner: On the basis and manner	of examinati	ion and/or inv	estination in n	ny opinion (death occurre	d at the time da	ate and of	lace and du	e to the cause	(s)
•	/ E <u>3</u> E 8		30. Name and address of person	tyta 1	d death (Item	23a) (Tune	Doc	5214	14	olw.Bi	12	-10	- 2000	0
	Sta	ate	Catherine Pa 31. Date filed (Month, Day, Year)	tyka, M. 32. Regi	strar's Signat	inai ure	Hosp	ital	8a	1timo	12	, md	212	15
DH	Registr	rar	DEC 1 S	2006	Johnson &	y A	sele)							

Baby Boy Lewis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec 1, 2006 **Physician** 9:17 DM Crandall Clarence /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 ☐ F 73 Director 228-34-9791 NC May 21,1933 Usual Residence of Decedent 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 DXYes 2 □ No Director Va Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or imust be r 22151 5531 Mitcham U.S.A. Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after d. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Be Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Contractor 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Crandall Rosa Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Price-Daughter 5531 Mitcham Ct Springfield, Va 22151 20b. Place of Disposition (Name of cemetery, crematory or other place)
Albert G. Horton 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/8/06 Suffolk, Va 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Carlos A. Howard Funeral Home 21. Signature of Funeral Service Licensee 436W.35thStreetNflk, Va23508 23a. Part1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days disease or condition resulting in death) /Medical Due to as a consequence of): Examiner Pe cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 No death? 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director; 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Medica Conta D. Rockville, MD 20850 M. ELSAYAAD

y, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 8 2006

Physician

/Medical

Examiner

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified

nd Mental Hygiene. marked other than

Health a

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

Physician /Medical

Examiner

burial-trar

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:05 PM COOPER. SYLVIA DECEMBER 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE CITY N/A SINAI HOSPITAL OF BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/28/1911 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours 1 □ M 2 🗑 F MD 213-05-4567 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No BALTIMORE Director MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 USA 6317 PARK HEIGHTS AVENUE #217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SECRETARY SECRETARIAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NOODLEMAN SADIE GREENBERG ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHEILA KRAMER / DAUGHTER 53 RAISIN TREE CIRCLE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 12/17/2006 | WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 7 days MYOCARDIAL INFARCTION ACUTE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 TCNSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2☑ No Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Director:

within 24 hours aft

To the Funeral Di

completely filled in

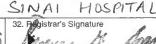
State Registrar

1ALWAR 31. Date filed (Month, Day, Year)
DEC 1 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SUMIT



and manner stated.

OF

29c. License number

BALTIMORE

29d. Date signed (Month, Day, Year)

DECEMBER, 14, 2006

	1- For State of Maryland / Registrar	Department of Health and M Certificate of Death	Mental Hygiene 005	40320
Physician	Decedent's Name (First, Middle, Last) Franklin Loy	Dove	2. Date of Death Month Day Year December 12, 2006	3. Time of Death 11:35 PM
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
	Joseph Richey Hospice	Baltimore		
Funeral Director	5. Social Security Number 579-42-7400 6. Sex 1 ★ 2□ F 7. Age (In yrs. last	Months Days Hours Min.	(Month, Day, Year)	thplace (State or Foreign ountry) rginia
P .	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
Aanyla f eho ed e		mbia		1⊠Yes 2□No
the h	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
Site death with the Mar infer death with the Mar for thems 23e or 28e-1 election	7680 Woodpark Lane #203	21046	U.S.A.	
deat deat	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		
1215-0036 within 72 hours after death with the Maryland ans. than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at ompleted by Funeral Director	1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give 7 Year or Dates:	1 ☐ Yes 2 🕱 No Specify:	Specify:	
5-003 72 hours natural;		6a. Decedent's Usual Occupation	16b. Kind of Business	ite /Industry
21215-00 ed within 72 hou gydene. Sydene. Tur the Medical is, the Medical is	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of worki life. DO NOT use retired)	ing	,
d 212 filed with Hygiene sther the ent, the	12	Painter	Housing	
be file oth	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Sumame)	
Nould Hould d Men marks	19a. Informant's Name/Relationship (Type, Print)	unknown Elva 9b. Mailing Address (Street and Number or Rura	al Boute Number City or Town State	unknown Zin Codel
Maryland 21215-0036 Maryland 21215-0036 nd 2 should be filed within 72 hours aff th and Mental Hygiene. 27 is marked other than "natural", or retaumatic event, the than "natural", or retaumatic event, the house Exami	Tammy Dove /daughter	7680 Woodpark Lane #20		
0 a a E E	20a. Method of Disposition 20b. Place		Date 20c. Location - City or	
Page Int. If or or inty or	1 🗆 Buriai 2 💢 Cremation 3 🗆 Hemoval from State	rundel Crematory Dec 1	8, 06 Odenton, Ma	aryland
Baltimore, permit. Pages 1 a Department of Hee Unportant: if them eny hojury or other space.	21. Signature of Funeral Service Licensee M0077	22. Name and Address of Facility Donaldson Funeral		_
7)	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.			Annrovimate
Second of the property of the	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent cause).	ce of):	¥ MIG WILL. METS	Interval Between Opset Set Death
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Is, P.O. Box 6 Is, P.O. Box 6 Is hat the death certificated by the attending be detached for use as by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pregnancy	23d. Date of de Month	livery Day Year
		g in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of deat
I Records, P.O. I Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached.			autopsy prior to death?	utopsy findings available completion of cause of
FVItal F Vital F Vicion: Th Visication: The director, pag	25. Was case referred to medical		h (Check only one)	
In of ing Physical distributions on: To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER	b. Time of 28c. Injury at Injury Work?	me 5 Residence Other (Spe 28d. Describe how injury occurred	ecity) HOPPIC
Division C Bivision C By Hospital or Attending P 124 hours effect death. 18 Funeral Director: Affect dietely filled in by the funeral pedical Certification:	2 Accident investigation 3 Suicide 6 Could number determined 28e. Place of Injury - At home building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No , farm, street, factory, office	28f. Location (Street and Number or R City or Town, State)	ural Route Number,
Hospi Houner Funer ely fill		dgs, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and dee to the cause(s) and manner a red at the time, date and place, and du	s statud. e to the cause(s)
To the Lympin 2 To the Complete	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	ttf. Day, Year)
5	30. Name and address of purson who completed cause of death (Item 23	William A I	The, Mel 21.	248
State Registrar	31. Date filed (Month, Day, Year) 32. Radistrar's Signature DEC 1 9 2006	1 Species		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 2154 hrs December 13, 2006 Medical Examiner Timothy Robert Dyson. Jr. 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Worcester Holly Grove & Rt. 50 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex Funeral Hours Country) Mary Land Director 1 X M 2 F 22 23 . 1984 218-23-0407 Usual Residence of Decedent 10d. Inside City Limits 10b Count 10c. City, Town or Location 1 Yes 2 X No 28a-f show Berlin or items 23a or 28a-f shomust be notified at once. Maryland Worcester death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 21811 S. 292 Ocean Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 X Married Yes White permit Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", on injury or other traumatic event, the Medical Examiner m Specify: Divorced If Yes, Give Year 1 Yes 2 X No specify 3 Widowed þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Real Estate Real Estate Agent 1 Year 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marea Alta Pearce Timothy Robert Dyson, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 292 Ocean Parkway, Berlin. Maryland 21811 Timothy R. Dyson, Sr. (Father) 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Dulaney Valley Memorial Gardens Burial 2 Cremation 3 Removal from State 12/22/2006 Timonium, Maryland Donation 5 X other) Specify Entombment 22 Name and Address of Facility Schimunek Funeral Home of Bel Air, 7 610 W. Macphail Rd., Bel Air, Md. 21 Signaty e of Funer e Licensee Schumather Fundade Home of Sec Act, Md. 10 W. Macphaul Rd., Bell Aut, Md. 22 P. I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and ailure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed and Physician/Medical g physician a AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Year Live birth Fetal death 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown Unknown the ed fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy · has performed? death? Yes 2 No 1 🗸 Yes certificate page 26.Place of Death (Check only one) 25 Was case referred to medical Be Other₄ Hospital: 1 Residence 6 Other Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 After this 1 🗸 Yes 2 28d Describe how injury occurred 28a. Date of Injury 28b Time of Injury 28c. Injury at Work? 27 Manner of Death Driver auto collision Dec 13, 2006 Certification 2149 hrs Natural Yes 2 V No Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town, State) Holly Grove and Route 50, Berlin, MD (Specify) Local Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number December 15, 2006 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State 9 2006 Registrar

ORIĞINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16a, b per fh 8862 12-19-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Cecilia Doski December 18,2006 12:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 □ M 2 □ F 215-12-4844 90 May 2,1916 Director Baltimore, MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 E. Joppa Rd. Apt. 209 21286 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No SpecifWhite 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Real Estate Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Appraiser At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Casimir Lewandowski Josephine Chmielewski ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela I. Thomas- Niece 722 Dulaney Valley Rd. #122 Towson, MD21204 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 12/19/2006 | Dundalk, Maryland 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility}Peaceful Alternatives Funeral&Cremation Center2325 York Rd.Timonium,MD21093 Funeral Service Lice 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lenout. Immediate Cause (Final Physician Years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death
9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy perforn 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) WSDCO Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide *Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

December 18 2006 29b. Signature 29c. License number 059303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST BOT MORE OUR ZIZEY 32. giştrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	of Maryla			t of Health e of Deat			giene	006	40323
	Dhuaisi		1. Decedent's Name (First, Middle, I							2. Date of Dea Month		Year	3. Time of Death
	Physici: /Medic			Anth		John	Dav:				ber	13,200	
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	Funeval		Franklin Square 5. Social Security Number 6.	e Hospit	a⊥ 7. Age (In yı	s. last birthe	(av) If Under	Rossvil	er 24 Hrs.	8. Date of Birth	1		more Co. hplace (State or Foreign
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	p .		Usual Residence of Decedent 10a. State 10b. County			City, Town o	or Location						10d, Inside City Limits
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	eme 2	Funerai	11. Marital Status		edent Ever in	U.S.	13. Was Deced	ent of Hispanic (ify Cuban, Mexic		ecify Yes or No- Rican, etc.)		4. Race - Ame Black, White	rican Indian,
9	or It	by Fu	XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	I 1 ☐ Yes If Yes, Gi	va Kik		1 □ Yes 🍹			,		Specify:	
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7	od with	Completed	12 Years				Bindi	ng			Kava	anaugh	Company
מום	tal Hy	Be	17. Father's Name (First, Middle, La							(First, Middle,		Sumame)	
2	hould d Men marke	၉	Kenneth Lawrence		, Sr.	19b A	Asilina Address	(Street and Nun		ary Koul		Town State	Tin Code)
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	Page nent c int: #		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe					ce Corp.	12/1	8/2006	Tows	son, Ma	ryland
Saltimor	permit. Pages to Department of Hamportant: If Ite eny injury or of engineers.		21. Signature of Funeral Service Lic	ensee		_	22. Name an	d Address of Fac Ruck Fun	cility		Dune	dalk. I	nc.
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Š,	signer	۾	Part II. Other significant conditions	contributing to d	eath but not r	esuiting in ti	ne underlying ca	iuse given in Pai	π Ι.		baccous es 2□		the cause of death? obably 4 Unknown
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	ing PI		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Tin Inju		Bc. Injury at Work?		28d. Describe h	ow injury	Hangi	AG
DIVISION	ttend death stor: / the f	ertification:	2 ☐ Accident investigat 3 ☑ Suicide 6 ☐ Could not	KAC DOO'T	13,200			1 ☐ Yes 2		Sureide	YCO tond	-	\sim
2	after after Dire	ertil	4 Homicide determine	build	ing, etc. (Spe		, street, factory	, omco		City or Tow	n, State)	028 Fox	2 122
	pepite hours unere ly fille	Saic	29a. Certifier 1□ Certifying	Physician: To the	best of my k	nowledge, d	feath occurred a	at the time, date	and place, a	and due to the c	ause(s) a	ind manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Ex	aminer: On the b	ner stated.	nation and/	or investigation,	in my opinion, d	eath occurr	ed at the time, d	ate and p	place, and due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	, ,	١			License numbe	er			signed (Monti	
	1		20 James and add to the M	هـ(ا ∨،	puty		D'	18667			DC EV	her 15	,2006
	1	4	Pl1:0 Militelle	o completed cau	Se of death (em 23a) (T)	(pe, Print)	I'v walte	10 N	14 21	OC.	3	
	Sta	te	31. Date filed (Month, Day, Year)	32	egistrar's Sig	nature	Act No	uthon vil		-(- 61	<u> </u>	-	
	Registr	ar	DEC 19	2006	ALLEN .	15 1							

			For State 1 - State Registrar	e of Maryland		rtment of H			giene 0 0	6 40324
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath _	3. Time of Death
	Physici /Medic		Helen Anna Eurice					Month	16 dol	6 7:53pm
	Examin		4a. Facility Name (If not institution, give street and Franklin Sauare	- HOSO1	tal	4b. City Town, or	edale	>	balt	more
	Funeral	Funeral Director	5. Social Security Number 6 Sex		st birthday) Yrs.	Months Days	If Under 24 H	8. Date of Birti (Month, Day 11/08/	h v. Year) 1020	9. Birthplece (State or Foreign Country) Marriland
	Director		220-09-5517 Usuel Residence of Decedent	00				11/00/	1920 1	Maryland
	how		10a. State 10b. County		Town or Lo					10d. Inside City Limits
	Ba-f		Maryland Baltimore	Mic	ddle R					1 ☐ Yes 2 X No
21215-0036	Mith II		106. Street and Number 107. Zip Code 6936 Gunder Avenue 21220				i	10g. Citizen of Wh	nat Country?	
	ns 23		11 Marital Status 12. Was	Decedenf Ever in U.S	i. 13. V	Vas Decedent of H	ispanic Origin?	(Specify Yes or No-	14. Race	- American Indian,
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at anone.	by Fun	1 Never Married 2 Married 1 Yes	d Forces? les 2⊠No , Give or Dates:	11	fYes, specify Cuba □ Yes 2፟፟ No	Specify:	ierto Rican, etc.)	Specify:	White, etc. White
	stural	To Be Completed t	15. Decedent's Education	or Dates.	16a. Deced	lenf's Usual Occup	ation		16b. Kind of Bus	
215	hin 72		(Specify only highest grade completed [Specify only highest grade comp	ted) ge (1-4or 5+)	(Give	kind of work done of NOT use retired	during most of (ii)	working		
21	ed wit			5+	Costu	me Desig	-		Theatre	
pu	be fill ntal Hy od oth		17. Father's Name (First, Middle, Last)					Name (First, Middle, ine Helen)
2	hould d Mer marke matic		Louis Lancaster 19a. Informant's Name/Relationship (Type, Print)		19h Mailin	n Address (Street		Rural Route Numbe		tate Zin Codel
altimore, Maryland	th an trau		James Eurice (Son)					Pasadena		
re,	s 1 ar if Hea item		20a. Method of Disposition	l car	ace of Dispos metery, cren	sition (Name of natory or other place	(e)	Date	20c. Location - C	ity or Town, State
E	Page nent o int: If iry or		1X Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)			1 Mem. G		20/2006	Baltimor	e, Maryland
Balti	permit. Departn Imports any inju		21, Signature of Funding Deputed Licensee	2	1	Name and Address BL	uzdzins Eastern	ki Funera Avenue,	l Home, : Essex, M	P.A. aryland 21221
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. on each line.	Do not ente	er the mode of dyin	ig, such as card	diac or respiratory ar	rest,	Approximate Interval Between
			Immediate Cause (Final disease) or condition							Onset and Death
			resulting in death)	ence all:			`			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a conseque	ence of):	1				
مح			cause. Enter Underlying Cause (Disease or injury that initiated events							
o	death certificate be executed e attending physician and of for use as the burial-transit		and the state of t	e to (or as a conseque	o (or as a consequence of):					
8760,	ate be	dica	d							
9 X	ding p	/Mec	IF FEMALE: 23c. If yes	If yes, outcome of pregnancy					22d Date	of delivery
Вох	that the death cer ed by the attendir detached for use	cian	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)	'			23d. Date of detivery Month Day Year		
P.O.	t the	ted by Physician/Medical	9 Unknown 9 U	□ Unknown						
	w requires that s been signed I should be det		Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
ord	law requires as been sign 2 should be		HE (1)(1)		1 🗹 Y e		es 2 No 3 Probably 4 Unknown			
ecc	<u>w</u> ~ c1	Completed	ventricular lachycarala				24a. Was an autopsy performed?			ere autopsy findings available for to completion of cause of
E E	Thate Page									ath? ☐Yes 2☐ No
V.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 npafient 2 E	P/Outpation	t 3 DOA Oth	0.00	Death Check only o		(Casata)
Division of Vital Records,		Medical Certification: To	27. Manner of Death 28a. D	28a. Dafe of Injury 28b. Time of 28c. Injury af 28d. Describe how injury occurred						
			1 ☑Natural 5 ☐ Pending (2 ☐ Accident investigation	(Month, Day Year) Injury Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
ivis							28f. Location (S City or Tox	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	Hospitel of the safe of the sa									nor as stated
	24 ho Fun etely		29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Appeck only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 39a. Certifier (Appeck only one) 49a. Certifier (Check only one) 49a. Certifier (Appeck one) 49a. Certifier (Appeck one) 49a. Certifier (Appeck one) 49a. Certifier (Appeck one) 49a. Certifier (Appeck one) 49a. Certifier (Appeck one) 49a. Certifier (Appeck one) 49a. Certifi							
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			> Alalausami	1		RES	3000	000	12-16	-2006
	10.		30. Name and address of person who completed	cause of death (Item	23а) (Туре,	Print)			1.1	
State 31. Date filed (Month) Day, Year) DEC 1 9 2006 State DEC 1 9 2006) >q.	un ba	Himore	ma 21237
3	Sta Regist	ate rar	DEC 1 9 2006	Jessellar & Signatu	y do	Back P	•			
	N.		DEOT A FOOD	A NOW THE WAY	67					

			1 - For State Registrar	State of M		d / Depa		t of H	ealth a				20	06	40325
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of Dea Month	Day		Year	3. Time of Death
	/Media	al	Edith Mae Earlin 4a. Facility Name (If not institution, give			-	4h City	Town or	Location o	f Death	Decemb			2006 y of Death	10:30 P ^M
a ·	Examin	ier	Manor Care Health					svil						imore	Э
	Funeral Director		219-18-8940	7. Ag	90 (In yrs. I 83	as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birt (Month, Da 10/15/1	h y, Year) 923		Cour	place (State or Foreign http) yland
	ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							1	10d. Inside City Limits
	a-f sh	ctor	Maryland Cecil		Cc	olora									1 ☐ Yes 2√CXNo
	with th	Dire	10e. Street and Number	n o			10f. Zip	Code 2191	7			_		What Cour	ntry?
	Maryland Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What 123 Mount Rocky Lane 21917 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1. Wes Pacify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W												can Indian,		
920	ours after or iter	ğ	1 ☐ Never Married 2 ☐ Married 3♥♥Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2/5 If Yes, Give Year or Dates:			lf Yes, spe 1 □ Yes		n, Mexican Specify:	, Puerto f	Rican, etc.)		Bla Specif	ck, White, ^{fy:} Wh	etc. nite
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event. I'm Medical Exam at minat be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or	5+)	16a. Deced (Give life. Homer	kind of wo DO NOT u	rk done d se retired	lurina most	of workii	ng			lusiness/In	dustry
d 2	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)			HOME	ilanet		18. Mothe	r's Name	(First, Middle,				
/lan	wid be Mental arked c	To B	Harry E. Horning						Glad	ys A	llender				
	is 1 and 2 sho of Health and P item 27 is me other traums		19a. Informant's Name/Relationship (T) Edward Deems (Son)	/pe, Print)			_				Route Numbe Colora,	-			
Baltimore,	of He if item or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ I	Removal from State		lace of Dispo emetery, crer					ate			- City or To	
Him	permit. Pages Department of I important: If It any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Fineral Service Licens		Hol										Maryland
Ba	Depa impo any ir		21 Signal(I) B OF Freial Service Ciceri	99			1407	nld i	ůzďží: Easte	nski rn A	Funera	l Ho	me,	P.A.	land 21221
NG.	Physician /Medical Examiner		23a. Part Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that cause ne cause on each I	ine. イン a consequ	n. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death
68760, %	cate be executed oblysicien and the burial-transit	dical Examiner	Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as	eral	Vas	ula	· /	clise	9950	7				
P.O. Box 6	The law requires that the death certificate the has been signed by the attending physologie 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥□No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic p					2		ate of delive	ery Day Year
	quires that the signed by all be detacted	b	Part II. Other significant conditions co	ntributing to death t	out not resi	ulting in the u	nderlying o	ause give	en in Part I.			obacco u res 2 [he cause of death?
Vital Records,		Completed								_				Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
/ita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:				Oth			Check only o				
of	Attending Physic death. ctor: After this copy the funeral dir	tion: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigation	1 Inpati 28a. Date of fnji (Month, Da		ER/Outpatier 28b. Time o Injury		28c. Injury Work	al	2	ne 5 Resid				(y)
Division	al or Atter s after dea il Director d in by the	Sertification:	3 Suicide 6 Could not be determined	28e. Pface of In building, e	jury - At ho tc. (Specify	ome, farm, str	reet, factor	y, office		2	28f. Location (\$ City or Tox			ber or Rura	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledicai C	29a. Certifier Check only 2 Medical Exam	rsician: To the best iner: On the basis of and manner si	of examinat										
	To the within 2 To the complet	Me	29b Signature and title of certifier	^ 1	24	2	29	c. License	number	<u> </u>					Day, Year)
			Melia	idon.	MI	7	<	02	69	79		9 -	18	-70	006
	5		30. Name and address of person who co	n JEV:	500	LUSD	od	Rd	ste.	(0)	Obu	B	LL Y Y	rie,	MB1261
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 9 2006	32. Regist	rar's Signa	ture	es o								

FISHER, (ECE)

			For State Ragistrar	State of Maryl	•	tificate of L		_	Rag. No.	06	40326
	Physicia	an	1. Decedent's Name (First, Middle, Las. Cecelia	Α.		Fisher		2. Date of De Month	Day	Yeer	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, or		Decemb	4c. Count	2006 y of Death	7.40 [
	Funeral Director	CI	5. Social Security Number 8. Sec. 214-22-5767	x 7. Age (In	Hmore yrs. last birthday) 30 Yrs.	Baltin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birn (Month, Da 02 04	th Y. Year) 1 26	9. Birth	place (State or Foreign
			Usual Residence of Decedenl								
arylar	ahow ad at	2	MD NA		:.City,Town or Lo Baltimo:						10d. Inside City Limits 1 Y Yes 2 □ No
the M	28a-f	Director	10e. Street and Number	<u> </u>		10f. Zip Code			10g. Cilizen of	What Cou	
with	3a or	io is	3703 Mohawk Ave			212	207			.S.A	
death	ema 2	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Vas Decedent of Hi		pecify Yes or No o Rican, etc.)			can Indian,
urs after	al', or its	þ	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	1 ☐ Yes 2♥ No If Yes, Give Year or Dates:	1	☐ Yes 🎇 No	Specify:		Speci		
IIIU X IX I 3-0000 be filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exeminer must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	le completed)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done d OO NOT use retired)	ution luring most of wor)	king	16b. Kind of E	Business/In	dustry
d with	Hygiene. ther than	mo	12th grade	Cotlege (1-4or 5+) na	Dist	turbutio	n Dept	•	Sinai	Hos	pital
ב ביים ביים	d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,		me)	
ar yra	d Mental narked c natic ave	မှ	Edward Hollie 19a. Informant's Name/Relationship (7	ima Drintl	10h Mailin	g Address (Street a		. Will:		State 7in	o Codel
and 2 st	Ith and 27 is m traum	Y i	Arlene Fisher-D			West La			-		2121
ע	of Hea fitam r other		20a. Method of Disposition	20		sition (Name of natory or other place		Date	20c. Location		
Page 5			Marial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State				2/21/08	5 Owin	gs M	ills, Md
Definit. Pages	Department of Important: if any injury or ones.		21. Signature of Funeral Service Licen	Shompe	M 4	Name and Address arch F/H 300 Waba	s of Facility I West ash Ave	, Balti	imore,	Мд	21215
1	hysician and hysician and hysician supplies the privile transit	edical Examiner	23a. Part. Inter the disease, or compositive, wheat failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or as a cor b. ASPI	Myoconsequence of):	ardial I	. 4	ion	rrest,		Approximate Interval Between Onset and Death
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wrequires that the	signed by	d by Ph	Part II. Other significant conditions of Hundertens	-	t resulting in the u	nderlying cause give	en in Part I.	23e. Did t			he cause of death?
Tec.	has Je 2	ompleted by						24a. Was autop perfo	an 24b. psy prmed? 2 2 No	Were autoprior to codeath?	opsy findings available ompletion of cause of
	certificate rector, pag	Bec	25. Was case referred to medical examiner?		7.0			ath (Check only o	/ ` _		2010
TO syde	this di	ုင္	Yes 2 □ No 27. Minner of Death 1 Natural 5 □ Pending	Hospitat: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2D ER/Outpatier 28b. Time of tnjury		4 🗆 Hursing r	lome 5 ☐ Resi	dence 6 □Ot how injury occu		(y)
DIVISION	after death. i Director: After d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Al home, farm, str		Yes 2 □No	28f. Location (. City or To	Street and Num wn, State)	ber or Rura	al Route Number,
J Signatura	within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 15 Certifying Ph	ysician: To the best of my	y knowledge, deati	occurred at the tim	ne, date and place	and due to the	cause(s) and m	anner as s	stated.
- E	hin 24 tha F mplete	Medical	one)	and manner stated.	and of the	29c. License		and at the title,			
۲	2 5 8		29b. Signature and title of certifier	/ 6	ino	7	1/	7	29d. Date sign		
, -			30. Name and address of person who	pmpleted cause of death	(Item 23a) (Type.	Print)	1777	/	12	-12	-06
0	U		Jay Fran	Kel		Sinai H	capital	of BaH	imore	2401	-06 W. Belvedere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar	otate of Maryland / L	Certificate of L		arrrygie Reg.	2000	40327
	Physic		1. Decedent's Name (First, Middle, Las Alice L. Furbee	St)			ate of Death	43, 2006	3. Time of Death 11:10 A M
	/Medi Examii		4a. Facility Name (If not institution, give Oakcrest Care Ce	e street and number) enter	4b. City, Town, or Parkvi	Location of Death		4c. County of Death Baltimore	
Less	Funeral Director			07	thday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Da Hours Min. Se	ate of Birth	9. Birth Coul	place (State or Foreign ntry) ryland
	Maryland -f show fed at	tor	Usual Residence of Decedent 10a. State 10b. County Baltimo	ore 10c. City, Town	or Location 7ille				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a ist be noti	al Director	10e. Street and Number 8832 Walther Blvd	a.	10f. Zip Code 21234		10g.	Citizen of What Cour	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fijury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Specify Yon, Mexican, Puerto Rican, Specify:	es or No- etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
15-0	n 72 hc " natu l edical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	ation furing most of working	16b Pe	. Kind of Business/In	dustry weII
212	d within giene. er than the M	Omo	Elementary/Secondary (0-12)	College (1-4or 5+)	cretary)	He	eather	
Maryland 21215-0036	uld be file Mental Hy arked othe	To Be (17. Father's Name (First, Middle, Last) Bennett W. Bruffe	∍у		18. Mother's Name (First, Annie H. Ha	Middle, Maid	den Surname)	
, Mar	s 1 and 2 sho of Health and item 27 is ma other traums		19a. Informant's Name/Relationship (7 Caroline McClausla	ype. Print) and-Executor 96	Mailing Address (Street a	nd Number or Rural Rout itt Ave. Car	^{e Number, Ci} ney, M	ty or Town State, Zip D 21234	Code)
Baltimore,	Pages 1 ment of H ant: If iter lury or oth		20a. Methord of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Tolldor	Disposition (Name of y, crematory or other place i Park Cemce:	^{Date} ry 12/19/20		Location - City or To	
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licen	see Mi Lada	Evansantwee 8800 Harfor	rᾩhapel&C rd Rd. Parkv	remati ille,	on Service MD 21234	es-Parkvill
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. Do not cause on each line. a. Frod 3 tage Due to (or as a consequence of			ratory arrest,		Approximate Interval Between Onset and Death
68760,	ertificate be executed ing physician and e as the burial-transit	Medical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or Due to (or as a consequence or					
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Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	0	26. Place of Death (Chec		TE TES	2[] 110
ō	Phys er this eral dir	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury 28b. Ti		4 12 Nursing Home 5		6 ☐Other (Specify	"
ion	ending F ath. or: After he funer	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		jury Work?	es 2 □No	Scribe flow in	ijury occurred	
<u>N</u>	Hospital or Attenc 24 hours after death Funeral Director: stely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farr building, etc. (Specify)	n, street, factory, office	28f. Loc Cit	eation (Street y or Town, Sta	and Number or Rura ate)	Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	one)	rsician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	or investigation, in my op	inion, death occurred at th	e to the cause ne time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
•	Voit To	2	29b. Signature and title of certifier		29c. License	number	29d. [Date signed (Month, L	Day, Year)
	1		30. Name and address of person who co	ompleted cause of death (Item 23a) (T	ype, Print)	646	D.	ecember	13 Zec/6
	10		Anna Monica 4	son in ly	· Calain	rd Parks.	lle, de	1) 212	34
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 9 20	32. Registrar's Signature	forli)				

DHMH 17 Rev 1/2001

Alice Furbase 12/13/300611:10 AM

			1 - For State Registrar	State of M	Maryland / [artment <i>tificate</i>			and M		ienę	2006	4032	8
	Physic		Decedent's Name (First, Middle, Paul Feaser	Last)					`		2. Date of Deat Month December	Day	y Year 6 2006	3. Time of Death	
	/Medi Examir		4a. Facility Name (If not institution,	give street and number	er)		4b. City,	Town, or	Location of	f Death	Decembe	7	County of Dea		
			Carroll Luthera				We	estm	inist			1	Carroll		
	Funeral Director		5. Social Security Number 216-28-5806 Usual Residence of Decedent	. Sex 1 1 M 2 □ F	Age (In yrs. last bin	thday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 10/14/	Year) 28	9. Bir Mar	thplace (State or Forei ountry) yland	gn
	land ow		10a. State 10b. County		10c. City, Towr	n or Loc	cation							10d. Inside City Limi	ts
	a-f eh	tor	MD Balti	more	Ra	anda	allsto	own						1 🗆 Yes 2 🕍	10
	or 28	Director	10e. Street and Number				10f. Zip				1	0g. Citi	izen of What Co	ountry?	
	s 23a	rail	4901 Old Court						21133				USA		
326	should be filed within 72 hours after death with the Maryland Menial Hygiene. marked other then "netural", or items 23a or 28a-f ehow imatic event, the Medical Examinar ritual be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	If Yes Give	s?		Vas Decedo Yes, speci		spanic Orig n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify:	te, etc.	
- -	72 hor	ted	15. Decedent's (Specify only highest of	Education	1 .	Deced	ent's Usual	Оссира	ition			16b. Kii	Wh nd of Business	ite /Industry	
21	ithin 7.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. D	OO NOT use	e retired)	luring most	of workii	ng			•	
Maryland 21215-0036	ould be filed within 72 Mental Hygiene. arked other then "nef atic event, the Medici		12 17. Father's Name (First, Middle, La	0		Me	echan:		10 11-11-	4. 51	(E) . A() . ()		achiner	У	
and	d be f ental l	To Be	William Feaser	3()							(First, Middle, M	faiden	Sumame)		
ary Z	2 should and Men le marke	F	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing	Address	(Street a			i Route Number,	City or	r Town, State, 2	Zio Code)	
	as 1 and 2 should to of Health and Ment litem 27 le marked rother traumatice		Cheryl Barahona	/ Niece							sville,				
Baltimore,	of He of He if item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from Stat	20b. Place of cemeters	Dispos y, crem	ition (Name atory or oth	e of ner place)	TART -			cation - City or		
Ē	i. Pages tment of tant: If it		4 Donation 5 Other (Spec	city)	Loudon	-			L	2/19	/06 1	Balı	timore,	Maryland	
E E	permit. Pages Department of I Important: If Ite eny Injury or of		21. Signature of Funeral Service Lic	ensee					s of Facility	110	udon Pa:				
			23a. Part1. Errer the disease, or on shock, of heart failure. List on	mplications that cause	ed the death. Do n	ot ente	the mode	ilke	ns Av	e. B	altimor	e, 1	Marylan	d 21229 Approximate	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Athei	SCIEK	h	cC	ard	liova	asc	ular	D	isear	Interval Between	
	Examiner		Sequentially list conditions	b		.,.									
	D T	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence o	il).									T
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence o	f)·									_
2/60	sician buria	dicalE		500 (0) 0	3 & 00113044061100 0	.,.									
200	tificate g phy: as the	ledic		0											
O. BOX	The law requires that the death certificate be executed ate has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pred Other (spec					2	3d. Date of deli Month	very Day Year	
	that the ed by detac		Part II. Other significant conditions	contributing to death	but not resulting in	the unc	teriving car	ISA GIVA	in Part I		23a Did tob	1	ee contribute to	the cause of death?	
ecords,	w requires that the de been signed by the should be detached	eted by		•		-			- In Fait 1.		1 Tes				n
		Completed									24a. Was an autopsy perform	ed? ≅oNo	24b. Were au prior to death? 1 ☐ Yes	topsy findings available completion of cause of 2 No	8
	sicial s certifirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Other			Check only one	_			
5	9 Phys erthis eral di	n: To	27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		me of		: Injury a Work?	4 L-Nurs		e 5 ☐ Residen			ufy)	
0	ath. ath. or: Aft	atio	Pending 5 Pending 2 Accident investigation	non	ay rear) Inj	jury	м		es 2□No	i		. ,			
DIVISION	tal or Atters as after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of in	jury - At home, farr tc. (Specify)	m, stree	et, factory, o	office		2	8l. Location (Stre City or Town,	et and State)	Number or Ru	ral Route Number,	_
:	to the hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 12 Certifying P 2 Medical Exa	hysician: To the besi miner: On the basis and manners	of examination and	death o	occurred at estigation, in	the time my opir	, date and nion, death	place, ar occurre	nd due to the cau d at the time, dat	ise(s) a e and p	and manner as place, and due	stated. to the cause(s)	_
1	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	1				icense		,			signed (Month		
	. 1		10/10				1	14	512	5		2	1810	6	
1	$\mathcal{N}_{I,I}$		30. Name and address of person who	completed cause of	death (Item 23a) (T	ypa, Pi	Par	-1	We	chi.	an ila i'ı	103	- Mr	6 21157	,
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	40	2			311	- circly	rev	, -, ,	2.13 1	
	Registra		DEC 1 9 200	5 1 /40 00	All Santa	E Sec	Carlo Carlo								- 1

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State of Maryland / Department of Health and Mental Hygien	P006
Certificate of Death Rag. N	

			1 - For State Registrar	State of Ma		artment of H rtificate of L		nd Mental Hyg	giene	06 40329
	Physici /Medi			INKEL	STEIN			2. Date of Dea Month Dec.	Day	Year 3. Time of Death 11: 00 PM
	Examir	er	4a. Facility Name (If not institution, give LEVINDALE HEBREW			4b. City, Town, or BALTIMO		Death	4c. County	y of Death N/A
	Funeral Director		201 00 7 100	7. Age	(In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	8. Date of Birt Min. 01/05/	1924	9. Birthplace (State or Foreign Country) HUNGARY
	Maryland	lor	Usual Residence of Decedent 10a. State 10b. County MD BALTIMO	RE	10c. City, Town or Lo	GS MILLS				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the la or 28a-	Director	10e. Street and Number 13 RICHARDS GREEN		OWIN	10f. Zip Code	21117		10g. Citizen of	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itema 23a or 28a-f show appriatury or other traumatic event, the Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ※ No		n? (Specify Yes or No- Puerto Rican, etc.)	14. Rad Bla Specif	ce - American Indian, ck, White, etc.
21215-0036		Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (212)	cation e <i>completed)</i> College (1-4or 5-	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, MAKER	furina most oi	f working	16b. Kind of B	usiness/Industry
Maryland	ould be fill Mental Hy harked oth	To Be	17. Father's Name (First, Middle, Last) (UNKNOWN)		FRIE	1	(UNKN		(UNKNOV	WN)
e, Mar	and 2 sh lealth and m 27 is m		19a. Informant's Name/Relationship (Ty SHERRY FINKELSTEI		N-LAW 13	RICHARDS			VINGS M	ILLS, MD 21117
Baltimore,	Pages 1 Iment of H tant: If Ita jury or ot		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	BETH JACO	B CEMETER	Y 12	2/18/2006	FINKS	- City or Town, State SBURG,MD
Bai	Depar Impor any in		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compl	Zum		900 REIST	ERSTOW		PIKESVII	ROS., INC. LLE, MD 21208
8760,	Physician Medical Examiner Streen Physician and Phys	dlcal Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	ð.	l cance		lungs with		Approximate interval Between Onset and Death Stroits 6 mm/l
P.O. Box 6	that the death certifi ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 DANo 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
Records, P.	requires been sign should be	Completed by Ph	Part II. Other significant conditions con Chronic atrial Hyperteus; on	fibrullati	not resulting in the ur	nderlying cause give	n in Part I.	23e. Did to	es 2 🗆 No	ribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available
tai Re	ysician: The law lis certificate has director, page 2 (25. Was case referred to medical		1			1 Yes	med? c	prior to completion of cause of death? 1 Yes 2 No
> =	hysicia his cert i direct	To Be	examiner?	ospital: 1 Inpatien	t 2 ER/Outpatien	3 DOA Othe		Death (Check only or ng Home 5 \subseteq Reside		er (Specify)
Division of Vital	To the Hospital or Atlanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; F.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury			28d. Describe ho	ow injury occurr	red
آ م	utal or A		4 Homicide determined	building, etc.	(Specify)			City or Town	n, State)	er or Rural Route Number,
:	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Aedical	one)	sician: To the best of ner: On the basis of e and manner state	examination and/or inv	estigation, in my opi	nion, death c	boc. and due to the e	ausu(s) and ma ate and place, a	and due to the cause(s)
,	viti To	Σ	29b. Signature and title of certifier	, mb		DOO				d (Month, Day, Year)
	, }		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type I	ALE, 24	134	WEST BE	LVEDE	RE AVE,
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1 15()		-1613		

State Registrar

MO

32. Registrar's Signature

WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen M. Gordon

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

6:25a.

MD

10d. Inside City Limits

1 ☐ Yes 🏖 ☐ No

21163

21215 Approximate Interval Between Onset and Death

¿ years

Year

21204

neeks

Day

Baltmore MD

9. Birthplace (State or Foreign

Black

Registrar DHMH 17 Rev 1/2001

State

10565 N.

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houlds & PPE203

			For State Registrar	State of Ma	ryland / Depa	artment of		and Menta	al Hygie Reg.	7 11 1	6	40331
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MINERVA	GROS	2				te of Death	H.	ear OC6	3. Time of Death 310 A . M
	Examin		4a. Facility Name (If not institution, give s Northwest Hospi	ital			ndalls	stown		4c. County of Bal	Death .tim	ore
	Funeral Director		5. Social Security Number 6. Sex 214-22-3672	7. Age	(In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Day		Min. 8. Dat (Mc O8	of Birth onth, Day, Ye	09 9	. Birthpla Country	ice (State or Foreign y) MD
	e Maryland la-f show tiffed at	ctor	10a. State 10b. County MD Baltimo	ore	10c. City, Town or Lo Randa	llstow	n				100	d. Inside City Limits 1 ☐ Yes 2 🌠 No
	with the	Director	10e. Street and Number 4325 Star Circle			10f. Zip Code	1133		10g.	Citizen of Wha	t Countr	y?
36	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other then "naturel", or items 23a or 28a-f show event, the Medical Expining must be notified at	by Funeral		12. Was Decedent E Amed Forces? 1 ☐ Yes 2XN If Yes, Give Year or Dates:	0		f Hispanic Ori uban, Mexican	gin? (Specify Ye i, Puerto Rican,	pecify Yes or No- o Rican, etc.)		Race - American Indian, Black, White, etc.	
Baltimore, Maryland 21215-0036	vithin 72 hounde. ne. "nature n Medical E.	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	(Give	dent's Usual Occ kind of work don DO NOT use reti	ne during mosi red)	t of working		. Kind of Busin	iess/indu	stry
Z 5	a filed w Il Hygier other th	Be Col	8th grade 17. Father's Name (First, Middle, Last)	na	Se	amstre:		r's Name (First,			CI	eaners
ylan		To B	John C. Johnson					ecca Gr				
Mar	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ. Valerie J. Johns	· ·		ng Address (Stre				-		2113
ore,	jes 1 ar of Hea if item or othe		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispo cemetery, cres			Date		. Location - Cit		
Ē	permit. Pages Department of i Important: if it any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Meadowr			12/20/0)6 E	lkridg	e,	Md
Ba	permit. Departr Imports any inj		Eprime J.	Thomps	M 4	arch F 300 Wal	/H Wes bash A	št Ave, Ba	altimo	ore, M	iđ	21215
	Physician /Medical		23a. Part1 Enter the disease, or complication or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	DE	the death. Do not enter. EM ENTIA consequence of):		ying, such as	cardiac or respii	ratory arrest,		- 10	Approximate nterval Between Onset and Death
9760,	cate be executed by physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universing Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
O. Box 68	death certifi e ettending I id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Fetal death 3	Dectopic pregnar	ісу			23d. Date o	,	, ay Year
rds, P	law requires that the es been signed by th 2 should be detache		Part II. Other significant conditions con	tributing to death bu		nderlying cause (ED)NG			te to the	cause of death?
Vital Hecords,	The ete h page	Completed by	HYPERTENSION	DILATE	D CARO	010 M/0	PATH	_ _	a. Was an autopsy performed Yes 2	? deat	r to comp th?	sy findings available oletion of cause of
	sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	nt 2 ☐ ER/Outpatier	it 3□ DOA C	N	of Death Chec		0 000		
sion of	ding h. After fune	atlon: To	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injun (Month, Day	28b. Time of	28c. In		28d. De		njury occurred	<i>Брөспу)</i>	
Division	i Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, str (Specify)	eet, factory, offic	е	28f. Loc City	ation (Street y or Town, St	and Number o	or Rurai F	łoute Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examin	ician: To the best of er: On the basis of and manner stat	f my knowledge, deat! examination and/or in- ed.	vestigation, in my	opinion, deat	d place, and due th occurred at th	e time, date	and place, and	due to th	ne cause(s)
)	o T with	-	29b. Signature and title of certifier Downgroup	ry M	D	D	nse number 5 4 2 8	58	D E	Date signed (N	eonth, Da	enter
q	20		30. Name and address of person who con A May May May May May May May May May May	I Wan	ganagan	•		ty west	Hos	pital	(ente
	Sta Registr		DEC 1 9	2006 N	rs Signature	position						

			/pe or Print in State of Marylai	nd / Depa		Health and N	Mental Hy	•	40332
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) RALPH 4a. Facility Name (If not institution, give st	ARL GRO	SS MA		or Location of Death	2. Date of De Month	Day Year	
Examination Funeral Director	ner	10228 Queens Came1 5. Social Security Number 333-16-9497 紫		. last birthday) Yrs.	Ellicot If Under 1 Year Months Days	t City	8. Date of Bir (Month, Da AUG 4,	Howard	thplace (State or Foreign ountry) nois
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howard		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
ath with the a 23a or 28	Funeral Director	10e. Street and Number 10228 Queens Camel			10f. Zip Code 21042			10g. Citizen of What Co	
illed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither then "natural", or Itema 23a or 28a-1 show int, the Medical Extra circuit or an entitled at	þ	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in the Armed Forces? 1 X Yes 2 2 20 10 42 - Yes, Give 1 942 - Year or Dates:		Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 X No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Specify:	
within 72 ho ene. then "natur	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation	16a, Dece		upation e during most of work ed)	king	16b. Kind of Business	Industry
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itsm 27 Is marked othar then "any injury or othar traumatic event, If a Menta.	To Be Co	17. Father's Name (First, Middle, Last) Harry Grossman	4			18. Mother's Nam Bessie		Maiden Sumame)	-
and 2 sho lealth and h m 27 ls ma har trauma		19a. Informant's Name/Relationship (Type Theresa Grossman/W	Vife	10228	Queens		Ellicot	t City, MD	21042
Deficiency of the part of the popular of the popular of the part o		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	moval from State Me	cemetery, crer tro Cre		Inc 12/1		Baltimore,	
Physician /Medical Examiner	er	23a. Part1. Enter the disease, if complic shock, or heart failure. Alst only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	-1.	1-2	99 Frede	erick Rd E	saltımor	land, Inc e, MD 21228 w	Approximate Interval Between Onset and Death
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The lavate has	e Comple	25. Was case referred to medical				26. Place of Dea	1 Yes	prior to death?	utopsy findings available completion of cause of
Phys this	To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	1 28c. Inju	ther: 4 Nursing H	ome 5. Hesi	1	cify)
To the Hoapital or Attending Ph within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	ify)	reet, factory, office	•	City or To		
the Hoap nin 24 hou the Funer	Aedical	(Check only 2 Medicel Exemination)	cien: To the best of my kr er: On the basis of examin and manner stated.	owledge, deatl ation and/or in	vestigation, in my	opinion, death occu	, and due to the rred at the time,	date and place, and due	to the cause(s)
with To com	M	29b. Signature and title of certifier E	r		29c. Licer	30641		December 18	2006
20		30. Name and address of person who con famula Saharpa	The 201-100	m 23a) (Type,	Print) Rev	w Neck	Roed	Baltimm	2006 Mayland 2/221
St Regist	ate rar	31. Date filed (Month, Day, Year) DEC 1 9 200	32. Registrar's Sign	de des	arter				•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 14, 2006 William David Griffith 5:55 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year June 10, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) 1√2 M 2□ F 92 Yrs. 1914 Maryland 217-05-8228 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehov the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23s or 21234 USA Apt. 1214 8820 Walther Blvd. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No δ Specify. 3 Widowed 4 □ Divorced White "naturel", SAFF, William D. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within I th and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker Assembly Line 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Griffith Ethel May Gent Edwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Health ar important: If item 27 is any injury or other trau. 2005. 13220 Falls Rd. Rev. McCarl Roberts / Friend Cockeysville, Md. 21030 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grace U.M. Church Cem. 12/21/06 Hunt Valley, Maryland 21. Signature of Fune al Service Li ensee 22. Name and Address of Facility 1050 York Road 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ruck Towson Funeral Home, Inc. Towson. Md. 21204 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) O 9□ Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □ No 1 Tyes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1- Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 crifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D61785

5

State

Registrar

Parhville, MD 21234

Etosha Dxon, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Walther

31. Date filed (Month, Day, Year) DEC 1 9

Boulevard

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU b Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Robert Bruce Graybeal December 16, 2006 2:00 P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Y Aug. 24, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex , 1934 Pennsylvania 1☐M 2□ F Days Hours 72 215-32-5285 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 Walker Street 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Mechanic State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Reba Elzie Wallen Bruce (nmn) Graybeal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristle L. Polk / Daughter 211 Heather Way, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Harford Memorial Gdns 12-19-06 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) nture of Funeral Serv McComas Funeral Home, P. A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the death, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

physicien and the burial-transit

Box 68760.

P.O.

Records,

Division of Vital

To the Hospital or Attending Physicien: within 24 hours efter death.
To the Funerel Director: After this certifice

permit. Peges 1 and 2 an

Physician

/Medical

Examiner

10a. State

11. Marital Status

Funeral

Director

ral', or iteme 23a or 28a-f ehov Express must be notified at

then

end Mental le marked

2121

Director

Funeral

δ

Completed

Be

Examiner

Physician/Medical

Completed by

Be

Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

. If yes, outcome of pregnancy 1□Live birth 2□Fetal death

3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify)

23d. Date of delivery Month

Day

to death but not resulting in the underlying cause given in Part I.

		tubate to the cap	
1 🗌 Yes	2 🗆 No	3 Probably	4 ∐Unkno

24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No ↑ Yes

1 Yes

Inpatient

2 ER/Outpatient 3 DOA

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one) Medical Examiner: On the bast of my knowledge, death occurred at the line, date and place, and due to the cause(s) and clather as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

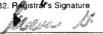
29b. Signative and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3a) (Type, Print) HARFORD MEMORIAL HOSPITAL, JOI SOUTH UNION AVENUE, HAVRE DE GRACE 21028

State Registrar



		_ FUI	artment of Health and Mental Hygiene 106 403 rtificate of Death Reg. No. 3. Time of D	
Physicia /Medic Examin	al	Shirley Catherine Harding 4a. Facility Name (If not institution, give street and number)	Month Day Year	A M
Funeral Director		Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-32-8764 1 □ M 2√√ F 71 Yrs.	Laurel Prince George's	Foreig
a-f show	ctor	Usual Residence of Decedent	ocation 10d. Inside City 1 Tyes 2	
72 hours a	Completed by Funeral Director	1 Never Married NM Married 3 Widowed 4 Divorced 1 Yes Aries If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent (Giv. [Giv.])	10g. Citizen of What Country? 20723 Was Decedent of Hispanic Origin? (Specify Yes or Noll 14. Race - American Indian, Black, White, etc.) 1□ Yes ¾XNo Specify: Specify: White dent's Usual Occupation a kind of work done during most of working DO NOT was ratired) 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White	
nd 2 should be filed within hit and Mental Hygiene. 27 ie marked other than "traumatic event, the Men	Be	Elementary/Secondary (0-12) Colfege (1-4or 5+)	ol Bus Contractor Public Schools 18. Mother's Name (First, Middle, Maiden Surmame) Margaret Miller	
ss 1 and 2 shouk of Health and Me litem 27 ie mark r other traumatii	ပ္	19a. Informant's Name/Relationship (Type, Print) 19b. Mail Susan Miles/Daughter 9033	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dumhart Road, Laurel, MD 20723	
permit. Pages 1 a Department of Hea Importent: If Item any injury or othe		4 Donation 5 Other (Specify) 21. Signators of Funeral Service Licensee	costion (Name of parametery or other place) Coln Cemetery 12/21/2006 Brentwood, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 13 Talbott Avenue, Laurel, MD 20707	
te be ysicie	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MRSA Pneum Due to (or as a consequence of): Due to (or as a consequence of):	spiratory Failure	een eath
death cert e attendin id for use	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5	□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Ye	Bar
e faw requires has been sign je 2 should be	Completed by Physician/Med	Part If. Other significent conditions contributing to death but not resulting in the Diabetes Mellitus II COPD	1 Yes 2 No 3 Probably 4 Un 24a. Was an autopsy performed? 24b. Were autopsy findings av prior to completion of cau death?	nknowi
ding Physicien: The After this certificete funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 No Natural 5 Pending (Month, Day Year) 25. Was case referred to medical examiner? 1 Inpatient 2 EP/Outpatient 2 EP/Outpatient 2 Sent Control of the Injury (Month, Day Year)		
To the Hospitel or Attending within 24 hours after death or To the Funeral Director: After completely filled in by the funeral	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Pface of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No	·8/,
the Hoepitel hin 24 hours a the Funeral t mpletely filled	Medical ((Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and due to the cause(s) and manner as stated. nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month. Day, Year)	
	~	29b. Signature and title of certifier Catholical Sauthonibe WD 30. Name and address of person who completed cause of death (Item 23a) (Type	D0064792 December 16, 2006	
Sta Registr		Kathleen Sarmiento, MD 7300 Van 31. Date filed (Month, Day, Year) 32. Registrar's Signature		

06-09506

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark Steven Haritos State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Deat Month Day December 13, 2006 **Medical Examiner** Mark Steven Haritos 1622 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** n/a 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Foreign West Hours Director 217-66-5951 1Х м 44 1962 Country Virginia 2 28, Yrs Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show notified at once. or 28a-f show Y Yes 2 No Maryland n/a Baltimore nours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 2313 James Street 21230 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Black pe Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. X Never Married 2 Married Yes If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify White "natural". þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 is marked other than Baltimore, MD 21215-0036 sernit Pages I and 2 should be filed within 7. Department of Health and Mental Hygiene U Mechanic Self 17 Father's Name (First Middle Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Steven G. Haritos Helen Galanos traumatic event, 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Mavronis / Sister 2313 James Street, Baltimore, Maryland 21230 Pages I and 2 shoment of Health and tant: If item 27 is or other traumat 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department o Bayview Crematory 12/18/2006 Baltimore, Maryland Donation 5 Other Specify 9 22. Name and Address of Facility Signature of Funeral Service/Dicensee Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, Maryland 21229 art). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a Chest injuries with compressional asphyxia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED ending physician use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes Yes 2 25. Was case referred to medica 26.Place of Death (Check only one) the Hospital or Attending Physician: Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this ဥ 1 V Yes 28a. Date of Injury Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Dec 13, 2006 Auto fell on top of subject Natural 1552 hrs 5 Pending 1 Yes 2 V No To the Funeral Director: the 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 4007 Barrington Road , Baltimore , MD (Specify) Local Street Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E December 14, 2006 mo 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32. Registrar's Signature ′2006 Contract of the Registrar

06-09420 Shirley Ann Hull

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jimey Ami Han		ertificate of Death	Reg. No 2006 1,023
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	2. Date of Month Decem	Death 2 3. Time of Death 3 and Death 1335 hrs
	4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center	4b. City, Town, or Location of Death Bel Air	4c. County of Death Harford
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 1 M 2 F		of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign Mainty Land
and show any nice.		y. Town or Location rest Hill	10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show uffied at once.	311 Forest Valley DR.	10f. Zip Code 21050	10g. Citizen of What Country? USA
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Pales:	If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Yes 2 No specify:) White, etc. White
5-0036 ed within 72 hours. tygene tygene other than "natur: he Medical Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
21215-0036 ould be filed within 7 Mental Hygiene marked other than ice event, the Medical TO Be Comple	12 2 17. Father's Name (First, Middle, Last) William Roberts	Secretary 18.Mother's Name (First, Mide Elizabeth	
MD 212 2 should be 1 h and Ments 27 is mark 1 matic even To B	19a. Informant's Name/Relationship (Type, Print) Raymond Hull, Jr Spouse	19b. Mailing Address (Street and Number or Rural Route 311 Forest Valley Dr.	Number, City or Town, State, Zip Code)
Baltimore, MD 21215-005 permit Pages I and 2 should be filed within Department of Feathth and Mental Hygiente Important: If item 27 is marked other it injury or other traumatic event, the Med	1 Burial 2 Cremation 3 Removal from State Me	Place of Disposition (Name of cemetery, crematory or other place) eadowridge emorial Park 12-14-0	20c. Location - City or Town, State 6 Elkridge MD
Balt permit Departi Import injury	21 Spr sture of Funeral Service License	²² Hame and Address of Facility Evans Funeral Chap Belair 3 Newport Dr	el&Cremation Service .Forest Hill.MD21050
Physician /Medical Examiner	failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence		Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause b. Due to (or as a consequence c.	of):	
evecuted an and al - transit	events resulting in death) Last Due to (or as a consequence d	of).	
760, cate be physici the buri	UNPENDED AMENDED IF FEMALE: 23b Was decedent pregnant in the 1 Live birth	Пени в Пении в Пении в померо	23d. Date of delivery Month Day Year
D. Box 687 the death certific by the attending I sched for use as tl	past 12 months? 4 Pregnant at time of c	death 5 Other (Specify)	
		1_	Oid tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
of Vital Records, ing Physician: The law requires After this certificate has been signeral director. page 2 should be on: To Be Completed			Was an autopsy findings available autopsy serformed? //es 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? // Yes 2 No No No No No No No No No No No No No
of Vital R Physician: T er this certific real director. p	25 Was case referred to medical examiner? Hospital Inpatient 2	26.Place of Death (Check only one) PER/Outpatient 3 DOA Other Other Nursing Home 5	Residence 6 Other:
Division of Vital Records, P.O. and or Attending Physician: The law requires that the safter death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	27 Manner of Death 28a Date of Injury		ribe how injury occurred
Q [= 4 8 8	3 Suicide 6 Could not be determined (Specify) Single Fa	amily 311 Fores	ion (Street and Number or Rural Route Number, City wn, State) st Valley Drive, Forest Hill, MD
To the Hos within 24 h To the Fun completely	Check only 2 Medical Examiner: On the basis of examination and manner stated	edge, death occurred at the time, date and place, and due to the and/or investigation, in my opinion, death occurred at the time, 29c. License number	cause(s) and manner as stated date and place, and due to the cause(s) 29d Date signed (Month, Day, Year)
	Jashang Deed	O.C.M.E.],
SITE	Tasha Greenberg MD. Assistant Medical Exam	miner 111 Penn Street, Baltimore, MD 21201	
State Registra	DECAG	. A franks	
DHMH 17 Rev 1/2001		ORIGINAL	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 December 14, **Physician** Elaine Marie Hubbard 7:33 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Min. March 11, 9. Birthplace (State or Foreign Becaeville 1943Newjersey 5. Social Security Numbe 156–34–7742 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 👿 F 63 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show MD Baltimore Baltimore 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 6669 Loch Hill Rd. 21239 USA 23a Funeral items ? Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. White Specify: 1 ☐ Yes 2 **D** If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō þ 3 □ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Carpet 17. Father's Name (*First, Middle, Last)* Herbert Schwab 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 654 E. 35th St. Baltimore, MD 21218 19a. Informant's Name/Relationship (Type. Print) Jennifer M. Hubbard-Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (realized) Evans Funeral Chapel 13/17/66 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Atternatives FUneral& Cremation Center 2325 York Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mosh **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine he law requires that the death certificate be executed nding physician and resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 1 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 | Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier uno

le St. Bolto and 2120x

State Registrar

Medical

6 Ame 6100 32 Registrar's Signature

30. Name an address of person who com leted cause of death (Item 23a) (Type, Print)

DEC 1 9 2006

Registrar

DHMH 17 Rev 1/2001

HINEBAUSH

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			For State Registrar	State of Ma	-	epartme Certifica				giene	16	40340
			Decedent's Name (First, Middle, Last)						2. Date of De.	ath		3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give s		1	4b. City	Town, or	Location of Death		4c. County	ol Death	
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	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birt		r 1 Year	If Under 24 Hrs.	8. Date of Birt	h		lace (State or Foreign try)
	Director		212 36 7243	M 2□F	68	rs. Months	Days	Hours Min.	8. Date of Bird (Month, Da Feb. 1.	2 1938	Mary.	land
	ס		Usual Residence of Decedent									
	nylan how		10a. State 10b. County		10c. City, Town	or Location					11	0d. Inside City Limits
	B-f-	cto	Maryland Baltimore		Essex							1 ☐ Yes 2 ☐ No
	th the	lre	10e. Street and Number			10f. Z	ip Code			10g. Citizen of W	hat Coun	try?
	death with the Maryland me 23s or 28s-f show r must be notified at	Completed by Funeral Director	1722 Old Eastern A	venue				21221		USA	L	
	dear dea	ne	11. Marital Status	Was Decedent E Armed Forces?	er in U.S.	13. Was Deci	edent of H	ispanic Origin? (Spo In, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race	e - Americ k, White,	
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- e	permit. Pages 1 and 2 should be fited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or iteme 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition		20b. Place of	Disposition (Na y, crematory or	ame of	oal [Date	20c. Location -	City or To	wn, State
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	/Medical Examiner		resulting in death)	Due to (or as a	a consequence o	of):						
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ō.	thet	Y P	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the underlying	cause giv	en in Part I.	23e. Did to	obacco use contr	ibute to th	e cause of death?
rds	quires to signer and be a	q p	renal insuffic	iency,	SVI,	Pulm	unar	4	101	res 2 ☑ No	3 🗌 Prob	ably 4 □Unknown
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ž	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At home, lar c. (Specify)	m, street, facto	ry, office		281. Location (S City or Tox	Street and Number vn, State)	er or Rura	l Route Number,
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	2		30. Name and address verson who con	np eted cause of de	eath (Item 23a) (Type, Print)			C		1	
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			For State Registrar	State of Ivit	ai yitai i		tificate			ATTO IVI	_	Reg. No	006	403	141
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	/Medic Examin		4a. Facility Name (If not institution,				4b. City	Town, or	Location of	of Death	Debenda		County of De		
			Baltimore V	A Medical	Cera	ter	6	sal	<i>tmor</i>				NI		
	Funeral		5. Social Security Number	5. Sex 7. Ag		last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da July 3	th y, Year)	9. B	irthplace (State o	or Foreign
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	th the	lrec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	Country?	
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	/-		30. Name and address of person w	elolisting	MD (Item	2391 /7	Print)	7-1	1 (-			Derei	mber 1	4,2006	
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		•	For State Registrar	State o	f Maryland		artment tificate			and M		giene	006	40342
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	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	mber)				Location o		Deceins		County of De	ath
			NORTHWEST HOST 5. Social Security Number	PITAL 6. Sex	7. Age (In yrs. Ia	ast hirthday)	R.		LLSTO		8. Date of Birtl	h	BALT	
	Funeral Director		228-16-6890	1 ☐XM 2 ☐ F	84	Yrs.		Days	Hours	Min.	(Month, Day 10-13-1	, Year)	7	irthplace (State or Foreign Country) VIRGINIA
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			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death each line.	. Do not ent	er the mode	of dying	, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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d)	has has	Completed	DECUBIT	102.							24a. Was a autop perfor	med?	prior to death?	autopsy findings available completion of cause of
	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes (Check only o	2 No ne)	1 🗌 Ye	s 2000No
<u></u>	Physician: this certifical director,	은	1 ☐ Yes 2 No			ER/Outpatien			4 🗀 197		me 5 Resid			ecify)
_ _ 0	ding f th. After funer	tion	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investig	9	of Injury oth, Day Year)	28b. Time of Injury	М 2	Bc, Injury Work 1 □ Y	at ? ′es 2.∐1		28d. Describe h	iow inj <i>u</i> ry	occurred	
Division	Hospital or Attending Physicien: 4 hours after death. Funeral Director: After this certificitiely filled in by the funeral director,	Certification:	3 Suicide 6 Could r	not be 28e. Place	of Injury - At ho ing, etc. (Specify	me, farm, str	eet, factory	, office			28f. Location (S City or Tow	treet and	Number or F	Rural Route Number,
5	urs aft eral DI													
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 X Certifyin (Check only 2/ Medical I	g Physician: To th Examiner: On the band man	e best of my know easis of examinat iner stated.	wiedge, death	occurred a vestigation,	in my op	e, date and inion, deat	d place, th occurr	and due to the ded at the time, d	date and p	and manner a place, and du	as stated. ue to the cause(s)
	With:	Σ	29b. Signature and title of contifier	17 100	chla	MT			number 410			29d. Date	signed (Moi	The Say, Year)
7	1.1		30. Name and address of person		se of death (Item	23a) (Tune							,	. , 20.0.
	2+1		MIRTH LIEST	Hosti	AL (ENTO		BA	MOA	US"	TOWN	m	Da	(1) 33
	Sta Regist		31. Date filed (Month, Day, Year)		Registrar's Signat									-
	negist	Tal	to by A T C	PARA LA	Supplied the	A STATE OF THE PARTY OF THE PAR	and the same							

			For Stete Registrar	State	of Marylar		artment rtificate					giene Reg. No.	006	40343
	Physicia	an	Decedent's Name (First, Middle, L BETS		Ε.		HAAS				2. Date of Dea	Day :	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, gr					Town, or	Location of	of Death	Decem		T 206	MAMM
	Cxamiii	C)	ROLAND PARK PL						BAL	TIMO	RE			N/A
	Funeral			Sex 1 □ M 21 <u>/</u> F	7. Age (In yrs. 94		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h 1019	9. Birth Con	place (State or Foreign untry) MD
	Director		Usuel Residence of Decedent		J-1						03/03/	1712		
	show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo								10d. Inside City Limits 1 Yes 2 No
	the Mi	ecto	MD N/A 10e. Street and Number			BAL	TIMOR					10a Citizan	of What Co	
:	3a or	Funeral Director	830 W. 40TH ST	REET			101. 2.10	0000	212	11		rog. Onizon	o. What oo	USA
	ter deat tems 2 trer mu	ıner	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexican	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	rs atte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, G Year or D	2 ሺ No ive Dates:		1 □ Yes 2		Specify:				ecify:	WHITE
21215-0036	i within 72 hours after death with the Maryland jiene, "Then "natural", or items 23s or 28s-1 show The Madical Examiner must be motified at	ted I	15. Decedent's I	Education			dent's Usua kind of wor			t of work		16b. Kind	of Business/I	ndustry
121	within / ene. then "r	Completed	Elementary/Secondary (0-12)	College ((1-4or 5+) 4	life.	<i>⋻ఄ</i> ౿ఀఀ៷౿ <i>ౘఴఄ</i> ѕ 1EMAKE	se retired,))	i oi worki	, ig	OMN	HOME	
	H the		17. Father's Name (First, Middle, Las			1101	ILIIAKE		18. Mothe	er's Name	(First, Middle,			
Maryland	2	To Be	RALPH	-			IRAIM			NNIE				FRANK
	12 = 12 = 12 = 12 = 12 = 12 = 12 = 12 =	7727	19a. Informant's Name/Relationship ELLEN LEVY / D				•				- BALT			
w	of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from	State	Place of Dispo cemetery, crei	matory or of	ther place			Date		ion - City or 1	
Ei I	permit. Pag Department Important: I any injury o once.		4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice	•	BAI	LTIMORE	HEBR						TIMORE	
Ba	Depa Impo any t		Rocal /	Zu		>					OL LEVI ROAD -			, INC.
			23a. Part1. Enter the disease, or conshock, or heart failure. List ont	y one cause on	each line.		er the mode	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	(or as a consec		1							
	Examiner		Conventinily list conditions	b	(0) 40 4 00 100	44401100 017.								
	B /√ ≅	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec	quence of								
Ć.	oxecut n and ial-tran	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):					. <u>. </u>			
09289	cate be executed physician and the burial-transit	Ical	· ·	d										
9 x	leath certifical ettending phy I for use as th	/Mec	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn							23d	. Date of deli	Verv
D. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and real director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown		birth 2 Peter nant at time of conown		Ectopic pro Other (sp						Month	Day Year
P.O.	res that th igned by be detact	/ Phy	Part II. Other significant conditions	contributing to o	death but not re	sulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	obacco use	contribute lo	the cause of death?
rds	quires nn sign uld be	ed by	Coronary	Arte	ry	LISEA	SE				101	res 2□N	io 3 Pro	bably 4 Unknown
of Vital Records,	e law requ has been je 2 should	Completed	history	OF C	olon	caro	uno	mA	<u> </u>		24a. Was autop	SV	prior to c	opsy findings available ompletion of cause of
<u>m</u>	ician: The Certificate harector, page				-						1 ☐ Yes	-	death?	2□ No
5	ysiciar iis certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 25 No	Hospital:	Inpatient 2] ER/Outpatier	nt 3 DO	Othe			me 5 ☐ Resid		Othor (Spec	4.1
	ding Phy I. After this funeral o	H 1	27. Manner of Death 1 Natural 5 □ Pending		of Injury onth, Day Year)	28b. Time o		8c. Injury Work			28d. Describe h			ay,
Sio	or Attending after death. Director: After in by the fune	catle	2 Accident investigati	on he			М	1 🗆 ,	Yes 2					
Division				d 289. Plac	e of Injury - At h ding, etc. <i>(Speci</i>	nome, farm, str fty)	reet, factory	r, office			28f. Location (S City or Tox	Street and N vn, State)	umber or Ru	ral Route Number,
	tal or Attend is after death al Director: / ed in by the f	Certifi	4 Homicide determine	build										
	hs Hospital or At n 24 hours after o he Funeral Direc pletely filled in by	edical Certification:	4 Homicide determine 29a. Certifier (Check only one) Certifying F 2 Medical Ext	Physicien: To the	e best of my kn basis of examina nner stated.	owledge, deat ation and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as	stated. Io the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certifi	29a. Certifying F (Check only 2 Medical Ex	Physicien: To the aminer: On the band man	basis of examination	owledge, deat ation and/or in	vestigation,	, in my or c. License	oinion, dea e number	ith occurr	ed at the time,	date and pla 29d. Date si	ice, and due	lo the cause(s) , Day, Year)
	To the Hospital or Al within 24 hours after To the Funeral Direc completely filled in by		29a. Certifier (Check only one) 29b. Signature and title of certifier	Physicien: To the miner: On the land mar	basis of examining the state of	ation and/or in	vestigation,	, in my or c. License	oinion, dea e number	ith occurr	ed at the time,	date and pla 29d. Date si	ice, and due	lo the cause(s) , Day, Year)
	To the Hospital or Al within 24 hours after C to the Funeral Direct completely filled in by		29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who	Physicien: To the miner: On the land mar	basis of examining the state of	m 23a) (Type,	vestigation,	in my op License D3	oinion, dea e number	ith occurr	ed at the time,	date and pla 29d. Date si	ice, and due	lo the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Lrvin 3:55 PM Linda December 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kandallstown Northwest Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) -56-0800 1 □ M 2 🕽 F Months Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director TIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or RRAGE 31133 11.5, Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 20 No
If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Year or Dates: BIACK or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1215 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type. Print) mel. 21202 nero 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injuny -16-66 21. Signature of Funeral Service Licensee 236. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial intarction /Medical Due to (or as a consequence of): Examiner artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Type II diab Dye to (or as a consequence of) diabetes and burial-trar Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12,months? Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fall 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Android 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. s case referred to medi al Anemia of renal diseures yes Chronic Kidney Hospital or Attending Physician: Be 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the fr 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kaston D28462 December 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Boston Center Randallstown, Maryland Hospital

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mont

Physici /Medi Examir

Funeral Director

	Plea	ase Type or								-		_	ible.	
	For State Registrar	State o	of Mar	yland /		artmer <i>rtificat</i>				/lental l		ne 0	06	40345
	1. Decedent's Name (First, Midd	le, Last)								2. Date of Month	Death	D	· ·	3. Time of Death
ı		Rober	t Eu	gene (Jack	son,	III				nber	18,	2006	5:50 A M
	4a. Facility Name (If not institution	on, give street and nu	mber)			4b. City,	Town, o	r Location	n of Death			4c. Count	y of Dea	ith
	2811 Louisiana	a Avenue				Hale	thoi	сре				Balt	imor	e
	5. Social Security Number	6. Sex 1 X M 2 □ F	7. Age (In yrs. last b	,	If Under Months	1 Year Days	If Unde	er 24 Hrs. Min.	8. Date of	Birth Day, Y	ear)	9. Bir	thplace (State or Foreign
	212-11-8057	IESINI ZUIF	32	2	Yrs.					Mar		,		
ŀ	Usual Residence of Decedent 10a. State 10b. County	,	1	0c, City, To	wn or Lo	ocation								10d Incide City Limite
			"	oc. ony, ro	MIT OF EX	Journal								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	MD Balti	more		Halet	hor	_						10d. Insi 10g. Citizen of What Country? U.S.A. 14. Race - American India Black, White, etc. Specify: White 16b. Kind of Business/Industry Electric Compa Maiden Surname) 17. City or Town, State, Zip Code) 18. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Chorpe, Maryland 19. Country 19. Country 10. Insi 10. Ins		
	10e. Street and Number					10f. Zip	Code				10g	. Citizen of	What Co	ountry?
	2811 Louisiana					21	.227				U	.S.A.		
	11. Marital Status	12. Was Dec Armed Fo	edent Eve	er in U.S.	13.	Was Dece If Yes, spe	dent of H	lispanic C an, Mexic	Origin? (Spean, Puerto	ecify Yes or Rican, etc.)	No-			
	1 □ Never Married 2 🔀 Mar	If Yes, Gi	ve		1	1 ☐ Yes		Specif		, ,				
	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates:		1			_,				Speci	Wh:	ite
í	15. Deceder (Specify only highe	nt's Education est grade completed)		16	(Give	dent's Usu	rk done i	durina ma	ost of work	ina	16	b. Kind of E	Business	/Industry
1	Elementary/Secondary (0-12)	College (1-4or 5+)		life.	DO NOT u	se retired	1)						
		4		I	Elec	trici	.an							Company
ı	17. Father's Name (First, Middle,	•						18. Mot	her's Name	e (First, Mia	ldle, Ma	iden Surna	me)	
-	Robert Eugene	Jackson,	Jr.					Daw	n Dai	rling				
1	19a. Informant's Name/Relations			19								-		• /
ž.	Nicole D. Jack	son /spou	se		281	1 Lou	isia	na A	venue	e, Hal	.eth	orpe,	Mar	yland 21227
	20a. Method of Disposition 1 ☐ Burial 2 【XCremation	O I Domoval from		20b. Place cemet	of Dispo	osition (Nar matory or c	ne of other plac	ce)	- [Date	20	c. Location	- City or	Town, State
	4 □ Donation 5 □ Other (5		State	W. Ar	und	el Cr	emat	ory	Dec 1	L9, 06	00	dento	n, M	arvland
ľ	21. Signature of Funeral Service	Lipensee												7
-	1 John He	a Ille		M0077	3	313 T	albo	tt A	erai ve. I	nome, Laurel	P. A	a. arvla	nd 2	0707-4389
Ì	23a. Part1. Enter In 1997 e, o shock, or heart III. Lis	r complications that	caused the	e death. Do									.iu 2	Approximate
ļ	shock, or heart silve. List Immediate Cause (Finar													Interval Between Onset and Death
	disease or condition resulting in death)	a		failu										4 days
		MI .	,	onsequence	,									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U		ry act		Tympr	opta	istic	Leu	kemia				20 months
	cause. Enter Underlying Cause (Disease or injury		(01 43 4 0	orisequerio	, OI).									
	that initiated events resulting in death) Last	C	(or 25 2 0	onsequence	of):									
ı		Due to	(OI as a C	orisequerice	oi).									
		d												
ŀ	IF FEMALE:													
	23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou 1⊟Live !		pregnancy ⊒Fetal deal	h 3[∃Ectopic pr	egnancy	,					ate of de	*
	1 ☐ Yes 2 ☐ No	4□Pregi 9□Unkn		ne of death	5	Other (sp	ecify)				-	M	onth	Day Year
ŀ	9 ☐ Unknown													
	Part II. Other significant conditi	ons contributing to d	eath but n	not resulting	in the u	nderlying c	ause give	en in Part	l.	23e. D	id tobac	co use con	tribute to	the cause of death?
										1	☐ Yes	2 ∑ No	3 □ Pi	robably 4 □Unknown
										24a. W		24b.	Were at	utopsy findings available
										aı	utopsy erforme	J?	death?	utopsy findings available completion of cause of
-	25. Was case referred to medica	1		-				20 =:		1□ Ye	s 2 🛭	No	1 ☐ Yes	2 K No
	examiner?	Hospital:	lanati	00000			Othe	er:		(Check on				
-	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	of Injury		utpatier Time of	nt 3□DC	8c. Injun	4 🗆 1		me 5X R 28d. Descri			, ,	cify)
. 1		Lou. Date	- i riguity	1 400.	THIT U	. 14	.vv. iiijuli	y al		∠ou. Descri	ue now ∣	ITHILITY OCCIL	ren	

Medical Certification

(Month, Day Year) Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one) 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D64644

29d. Date signed (Month, Day, Year) December 19, 2006

30. Name and address of person who sympleted cause of death (Item 23a) (Type, Print)

Brady L. Stein, M.D. 401 North Broadway, Baltimore, MD 21231

State Registrar

31. Date filed (Month, Day, Year)
DEC 1 9 2006



06-09536 Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland's Department of Health and Mental Hygiene Learnold Andre Jones 2006 1. For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) Reg. No 2. Date of Death Physician/ Month Day December 14, 2006 Medical Examiner 1145 hrs LeArnold Jones 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4214 Darleigh Road Nottingham **Baltimore County** 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9 Birthplace (State or **Funeral** oreign Months Days Hours Min Director 214-88-0786 Country) 1X M 2 F Yrs 73 33 02 12 MD Usual Residence of Decedent iny IOc. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No hours after death with the Maryland MD Baltimore Essex Director 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country 21221 1203 Damsel Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? White etc. 1 Never Married 2 X Married Yes 2 X No ᡖ Black 1 Yes 2 No specify: Widowed Divorced If Yes, Give Year Specify 'natural", 3 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 than, Baltimore, MD 21215-0036 Satellite Installation 12th grade 4yrs Direct TV of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Willie Willie Be Felder Bernice Jones ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print.) nt: If item 27 is m other traumatic e Alisa Jones-Wife 1203 Damsel Road, Essex, Md 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Metro Crematory Inc 12/21.06 Baltimore, MD Donation 5 Other Specify 21 Signature of Funeral Service Licenses Ma Yame and Address of Facility t 4300 Wabash Ave, Baltimore, 21215 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Gunshot wound to abdomen Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran Physician/Medical physician a the burial - 1 UNPENDED AMENDED certificate be Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? ✓ Yes 2 No 1 🗸 Yes 2 No 25 Was case referred to medical 26. Place of Death (Check only one) To the Hospital or Attending Physician: Division of Vital Be Hospital: 1 Inpatient Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes After 27. Manner of Death 28a Date of Injury 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: Dec 14, 2006 Subject shot by police Natural 0000 hrs Director: d in by the f 5 Pending Yes 2 V No hours after death 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4214 Darleigh Road, Nottingham, MD within 24 hours a To the Funeral I (Specify) Single Family 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

Drilly Rev 1/2001 OCMF 2006

State

29b Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

a

32 Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

sauce

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d Date signed (Month, Day, Year)

December 15, 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/15/2006 **Physician** Thomas Price Jones 7:26am /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's County Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday). If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2□ F 226-36-2297 Director 07/01/1931 VΑ Usual Residence of Decedent death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at MD Upper Marlboro Prince George's 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5200 Starting Gate Drive 20772 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after nend Mental Hygiene. Is marked other than "natural", or ite 1 Tryes 2 Ne/22 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Black <u>م</u> 3 Widowed 4 □ Divorced Year or Dates:4/281954 "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rubber Worker Tire Manufacturing 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sam Toy Jones Lottie Price permit. Pages 1 and 2 should I Department of Health end Ment Important: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Karon Johnson / Daughter 5200 Starting Gate Drive, Upper Marlboro, MD20772 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Highland Burial Park 1 ☐ Burial 2 ☐ Cremation 3 € Removal from State 12/20/2006 Danville, VA 4 ☐ Donation 5 ☐ Other (Specify) Cemetery ^{22, Name and Address of Facility}
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee W. Mardio 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Diabetes II Examiner Due to (or as a consequence of): Examiner Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Renal Failure P.O. Box 68760, Physiclan/Medical that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 XN0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Naturel 2 Accident 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗆 Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29b. Signature and title of certifier 29c. License number

D0059846

900 East Swan Creek Rd. Fort Washington, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wha

32 Registrar's Signature

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State Registrar GUILL

31. Date filed (Month, Day, Year)

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		1	For State Registrar	State of Ma		d / Depa		of H	ealth and N	Mental Hy		-	5 4034
Physi		1	1. Decedent's Name (First, Middle, I	ast) Mar	go		J	ohn	son	2. Date of De Month DECEMB	ath Day	Yea 4 2001	/ 1 co 7 % // L
/Med Exam Funera Directo	nine al	r é	4a. Facility Name (If not institution, g	ive street and number) L OF BAL Sex 7. Age	TIMOR	RE ast birthday) Yrs.	BAL If Under 1	TIM	Location of Death WRE CJ If Under 24 Hrs. Hours Min.	8. Date of Bird	th y, Year)	County of De	eath Sirthplace (State or Foreig Country) MD
aryland show d at			Usual Residence of Decedent 10a. State 10b. County		,	, Town or Lo							10d. Inside City Limit
or 28a-f se notified		Director	MD NA 10e. Street and Number		Bal	timor	10f. Zip (-	en of What	Country?
permit. Pages 1 and 2 should be filed within 72 hours affer death with the maryland Department of Health and Mental Hygiene. Important: If them Z7 is marked other than "natural", or flems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at		<u>a</u>	5325 Maple Av 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces?			Was Decede If Yes, speci 1 □ Yes 2	ent of Hi ify Cuba	215 spanic Origin? (Spn, Mexican, Puerto	pecify Yes or No o Rican, etc.)		Black, Wi	merican Indian,
within 72 hou ene. than "natura he Medical E		pleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12) L2th grade	Education grade completed) College (1-4or 5 na	i+)	(Give life.	dent's Usual kind of work DO NOT use Homem	k done a e retired,	uring most of worl	king	16b. Kir	nd of Busines	•
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th and Me	1	0 -	Lewis Dorsey 19a. Informant's Name/Relationship Carl Johnson-					(Street a	Dorothy and Number or Ru ve, Bal	ral Route Numb			e, Zip Code)
rages I an nent of Heal nt: If Item 2 iry or other		-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	20b. Pla	ace of Dispo emetery, crei	osition (Nam matory or ot	e of her plac		Date	20c. Lo	cation - City	or Town, State
permit. Departm Importa any Inju	ouce.		21. Signature of Funeral Service Li	arch	- 1	Ma 4.	2. Name and arch 300 W	F/H	s of Facility West sh Ave	Balti	mor	e, Md	21215
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The law requires that the death certificate to the lass been signed by the attending physionage 2 should be detached for use as the board.		Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	⊒Ectopic pre ⊒ Other <i>(spe</i>				2	3d. Date of o	delivery Day Year
been signed by the should be detached	1	d by Ph	Part II. Other significant condition	s contributing to death b	ut not resul	ilting in the u	ınderlying ca	use give	en in Part I.			se contribute	to the cause of death? Probably 4 🗹 Unknown
cate has been page 2 shou		Complete	HYPERTENS	011						24a. Was auto perfo 1∐ Yes		24b. Were prior to death	
I o the hospital of strending priystician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		Certification: To Be	25. Was case referred to medical examiner? 1	t be 290 Blace of ini	y Year)	ER/Outpatier 28b. Time o Injury me, farm, str	of 28	Bc. Injun Worl 1 □	4 LI Nursing H	ome 5 ☐ Resi 28d. Describe	dence (how injur	y occurred	pecify) Rural Route Number,
ne nospita in 24 hours he Funeral pletely filled		Medical C	29a. Certifier (Check only one) 1 ☑ Certifying 2 ☐ Medical E	Physician: To the best xaminer: On the basis of and manner st	f examinat	wledge, deat tion and/or ir	th occurred anvestigation,	at the tin	ne, date and place pinion, death occu	i e, and due to the urred at the time,	cause(s) date and	and manner place, and c	as stated. due to the cause(s)
To the P within 24 To the P complet		M	29b. Signature and title of pertifier	- , M.D.				_	S - 00 (5			er 14, 2006
20	Stat	е	30. Name and address of person w JASON Hu, 31. Date filed (Month, Day, Year)	ho completed cause of c	leath (Item 5) ar's Signat	23a) (Type, I NAI ture	Print) HOSPIT	AL	OF BAL	TIMORE			

		1	State of Maryland / Department	artment of Health and M rtificate of Death		iene 006	40349
	G		Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death
	Physicia /Medic		Henry P. Jackson		Decembe	r 18 2004	<u> </u>
	Examin		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Baltimore VA Medical Center 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Boltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	n/a	place (State or Foreign
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7	or 28	Director	10e. Street and Number	10f. Zip Code	1	log. Citizen of What Cou	intry?
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	tems	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene, Hydiene, the files 23e or 28a-f show that than "natural", or items 23e or 28a-f show ant, it e Marical Ever it with the notified at	by F	1 ☐ Never Married 2 ☐ Married I ☐ Yes, Give 1951 3 ☐ Widowed 4 ② Divorced Year or Dates: 1953	1 ☐ Yes 2 ☑ No Specify:	ack	Specify:	ack
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esî O	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. It iden 27 is marked other than "natural", or items 23e or 28e-1 show it item 27 is marked other than "natural", or item? I sat be notified at or other treumatic avent, to Modical Examinations.		Rodney B. Jackson - Son 609 20a. Method of Disposition 20b. Place of Dispo	Wallerson Road Ca	Itonsvil. Date	Le MD ZIZZ 20c. Location - City or	
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₽	It. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Specify) Metro Cro 21. Signature of Funeral Service Licensee	ematory Dec 2 Name and Address of Facility	18, 06	Baltimore,	_MI)
Ba	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tre		bim Marken	2 Name and Address of Facility Cremation Society	of Mary	land, Inc.	00
			23a Part Finter the disease, or complications that caused the death. Do not en	299 Frederick Road	or respiratory arr	ore, MD 212 rest,	Approximate Interval Between
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Vital Record		BeC	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only or	ne)	
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0	ding Ph th. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	Work?	28d. Describe h	low injury occurred	
SiO	r Attending er death. ractor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm is	M 1 Yes 2 No	28f Location /S	Street and Number or Ru	ral Route Number
Division	of or Attendated after death I Diractor: , d in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	City or Ton	m, State)	, ar riosto riamon,
	pite Durs Jera fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	, and due to the o	cause(s) and manner as	stated.
	24 hc 24 hc Fun etely	edical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	investigation, in my opinion, death occu	rred at the time, o	date and place, and due	to the cause(s)
	To tha Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	n, Day, Year)
	- > - 0		Racrel Harber M.D.	P21193	7	December	18,2006
-	. 1.1.1	1	30. Name and address of person who completed cause of death (Item 23a) (Type				
	1UT 1		Rachel Greenberg H.D., 10 North Green	e Street, Baltimore	Haryle.	and 21201	
10		ate	31. Date filed (Month, Day, Year) DFC 1 9 2006 32. Registrar's Signature	ele)	-		
	Regist	rar	DEC 1 9 2006				

			For	State of Maryland	/ Department of Health and	Mental Hygier	ie
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	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	/Medic	al -	CONSTANC		4b. City, Town, or Location of Deal	Dec	5 2006 2000 M
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	Funeral		5. Social Security Number 6. Sec	didi tel 1 properties	t birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign Country)
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	g , u		Usual Residence of Decedent 10a. State 10b. County	10c City 1	Town or Location		10d. Inside City Limits
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Maryland	12 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (T)		9b. Mailing Address (Street and Number or F	. 1	
	s 1 and 3 f Health Item 27 other tra	i ce	Michael Paige	e son	3743 limbertop	-	Location - City or Town, State
Ore	ges tof H fof H ff Ite or otl	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State	ce of Disposition (Name of Netery, crematory or other place)	19 - a- (B	L. L.
altimore	Departmen Departmen Importent: Iny Injury		4 □ Donation / 5 □ Other (Specify) 21. Signature of Funeral Service Licens		con our t Cremator / Dec	11, 2006 13	Service P.A.
Ba	permit. Pages Department of H Importent: if Ite any Injury or of once.		Delton C.	Dondan	1701 Mc Cullah S	t. Balto	hd. 21217
			23a. Part1. Enter the disease, or comp	lications that caused the death.	Do not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
	Physician		shock, or heart failure. List only of Immediate Cause (Final	a cerebrova	scular accident	-	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque			
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	St / 2	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a conseque	ince ot):		
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Box	leath certifica attending ph I for use as th	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of			23d. Date of delivery Month Day Year
	e deal	Sick	in the past 12 months? 1 □ Yes = 2 □ No 9>SUnknown	4☐Pregnant at time of dea 9☐ Unknown	ath 5 Other (specify)		
P.0	that the death cer ed by the attendir detached for use	Completed by Physician/Medical		ontributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Records,	signed to	d by	atrial fib	villation		1 ☐ Yes	2 □ No 3 □ Probably 4 【Unknown
Ö	w requir been si should	ete				24a. Was an	24b. Were autopsy findings available
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ta	an: Trifice	40	25. Was case referred to medical		26. Place of D	eath (Check only one)	
>	Physician: this certific ral director,	To B	1 Yes 2 No			Home 5 Residence	
0	ing Pl	- Lo	27. Manner of Death 1 Matural 5 ☐ Pending	(Month, Day Year)	28b. Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred
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	Hospital 14 hours Funeral tely filled	aic	25a. Cartifier 1 € Cortifying Ph	yulclan: To the best of my know	fiedge, feath coourned at the time, date and life	ou, and due to the cause	e(s) and manner as stated
	n 24 h	edic	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	on and/or investigation, in my opinion, death oc		
~	To the within 2 To the соптріе	Σ	29b. Signature and title of certifier	0	29c. License number		Date signed (Month, Day, Year)
	ŧ		> Doma E &	come no	P17678	D	ec 15 2006
	H		30. Name and address of person who				21201
			31, Date filed (Month, Day, Year)	32. Registrar's Signatu	reene St Baltim	me, MD	1101
	St Regist	ate rar	DEC 1 9 2806	Keed K	hate		
DI	HMH 17 Rev 1/2	-	DEG 1 3 4000	Justine M.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1 Per Phy G862 12/19/06 The Certificate of Death

Reg. No. 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year Sukhvinder Chana Kaur DECEMBER A M 11:06 2006 SURVINDER KAUR 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS DAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year)
Feb 29,1964 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
India Age (In yrs. last birthday **Funeral** Days Hours 1□M 2\ F 215-51-4108 42 Director Usual Residence of Decedent 10c. City, Town or Location sa or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with a and Mental Hygiene.

is marked other than "natural", or items 23a or ? 21222 India "natural", or items 23a 3127 Dunglow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Asian Indian þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Karam Bansal Kishan Singh မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tarlochan Singh, Husband 3127 Dunglow Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc. 12/16/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MacNabb Funeral Home P.A. 21. Signature of Funeral Service Scensee
Thomas Gregor Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HOURS a MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner b. SEPTIC SHOCK Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examiner certificate be executed burial-transi PNEUMOCYSTIS PHEUMONIA that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown KIDNEY FAILURE Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a, Was an autopsy certificate 1☐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

I Director: After din by the funera Certification: Division 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 houde , M.D DECEMBER 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATHIOUDAKIS M.D. 4940 ENSIGNANTE. BARTIMORE MD
Day, Year) 32. Registrar's Signature. NESTORAS 31. Date filed (Month, Day, Year) State A Separa Registrar 2004

	•	For State Registrar		;	State o	of Ma	ıryland		artment o			nd Me	ental Hy	/gien Reg. N	211	06	403	52
1 8.		Decedent's Name	e (First, Middle	ə, Last)								1	2. Date of D	eath			3. Time of D)eath
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/Medica		4a. Facility Name (I	f not institution	n, give str	eet and nu	mber)			4b. City, To	wn, or	Location of				c. Coun	ty of Death	1	
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Funeral		5. Social Security N		6. Sex			(In yrs. las	t birthday)	If Under 1 \	Year Days	If Under 2 Hours	4 Hrs. 8	B. Date of B	irth	r)	9. Birth	place (State or i	-
Director		213-28-56	96	1 🛂	/ 2□ F		75	Yrs.	Worth	Juys	110013	N	(Month, D larch	30,1	Ĺ931	Gree	nville,	N.C.
pu 💌		Usual Residence of 10a, State	Decedent 10b. County				10c. City,	Town or Lo	cation								10d. Inside City	Limits
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the N	ect	10e. Street and Nur		MOLC	COur	C.Y		CC y D V .	10f. Zip Co	ode				100.0	itizen of	What Co	untry?	
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12 sh h and h and r is n		19a. Informant's Na Nancy Kas			e, Print)				ng Address (S arren I				Route Numi SVill				ip Code) 21030	
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Pages tment of tant: If It		1 🖾 Burial 2 4 □ Donation	☐ Cremation 5 ☐ Other (S	pecify)		State		aney V	natory or othe Valley	Mei	m.Gar	• 20	.18, 006	Tin	noni	um, M	Maryland	
Cate be executed Medical Examiner and Street Physician and Street	in/Medical Examiner	23a. Par Int I show or lea Immediate Cause disease or conditic resulting in death) Sequentially list coif any, leading to meause. Enter Unde Cause (Disease or that initiated events resulting in death) in the condition of the c	Final north of the control of the co	a. b. c. d.	Due to Due to Due to	or as a corner of the corner o	TORY I	Do not ent ARRES nce of): nce of):	325 YOI er the mode o	rk]	Road	Tir	onlum	, Ma	aryl		21093 Approximate Interval Betwee Onset and De UNKNOWN	een eath
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or Attending Physician: after death. Director: After this certifice in by the funeral director.	Certification:	2 Accident 3 Suicide 4 Homicide	investi 6	not be	28e. Plac build	e of Inju	ury - At hom c. (Specify)	e, farm, str	eet, factory, o		165 2		3f. Location City or To			nber or Au	ral Route Numbe	ΘΓ,
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		1 H	10/1	18	DIX /	·W_	WIL		07	269	2			12/	/15/	06		
		30. Name and addi	ress of person	who com	pleted cau	ise of de	eath (Item 2	За) (Туре,	Print)									
10+1		Deborah 1	Bulloch	c, M.	D. 1	/A M	aryla	nd He	alth C	are	Syst	em 1	Perry	Poil	nt,	MD 2	21902	
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Registrar

DEC 19

2006

DECEMBER 14,

		-	For State Registrar	State of Marylan		nt of Health and te of Death	Mental Hygiene	1000 40004
	Physicia /Medic	an	1. Decedent's Name (First, Middle Last) NARION B.	KANE			2. Date of Death Month Day DECEMBER	3. Time of Death Y 2, 2006 1408 PM
	Examin Funeral	er	4a. Facility Name (If not institution, give s 5. Social Security Number 6. Sex	HOSPITAL 7. Age (In yrs.	last birthday) If Und	y, Town, or Location of Dea ALT MO er 1 Year If Under 24 Hrs s Days Hours Min	RE s. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	M 2 XF 55	O Yrs.	11000	3-2-5	MARYLAND
	the Marylar 28a-f ehow	ctor	10a. State 10b. County N-A	B	ry, Town or Location ALTIM	RE		10d. Inside City Limits
	23a or 2	ai Dire	1654 W. BE	LVEDER	E	Z1239		tizen of What Country?
036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or lleme 23a or 28a-f ehow ort, it a Madical Examinar must be modified at	Completed by Funeral Director	11. Marital Status 15 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:	.S. 13. Was Dec If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 200 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	d within 72 hours piene. Ir then "natural" Ine Medical Ext	ompietec	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Us (Give kind of v lite. IDO NOT	sual Occupation work done during most of we use retired) E-BOD4	orking 16b. K	HOUSE
Maryland 2	B is b	To Be C	17. Father's Name (First, Middle, Last) IRVING KI	ANE		18. Mother's Na	ame (First, Middle, Maiden Z/E K:A	NE
	nd 2 shoulth and 27 is my r treum		DROTHY . B	en Print)	19b. Mailing Addre	ss (Street and Number or F SERLY CT.	Rural Route Number, City of	or Town, State, Zip Code) WN MD . 21244
Baltimore,			20a. Method of Disposition 1 Rurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Place of Disposition (Notemberry, crematory of RBUTUS	r other place)	Date 20c. Le	ocation - City or Town, State 900. COUNTY MD.
Balti	permit. Page Department of Importent: If eny injury or ance.		21. Signature of Fune Al Service Licente	Lalmore	22. Name 1302	and Address of Facility	THE SH	CKS JR.F. HEME
•	rnysician /Medical Examiner		23a. Part1. Elter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Acute My	th. Do not enter the mi	ode of dying, such as cardio Infarcti Disease	ac or respiratory arrest,	Approximate Interval Between Proceed and Death Proceed Services Se
NS. 3760,	ate be executed sysicien and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) co	juence of): He ///	this		Unknown
P.O. Box 68	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 DEctopic			23d. Date of delivery Month Day Year
_ vî	uires that the signed by Id be detac	þ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlying	g cause given in Part I.		use contribute to the cause of death?
ARION I Record	The ate h pege	Completed	Down's Syno	rome			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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1,0	Phys r this sral di	٠ <u>.</u>	1 ☐ Yes 2 No 27. Manner of leath	1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)	PR/Outpatient 3 1 28b. Time of	28c. Injury at Work?	Home 5 Residence 28d. Describe how inju	
S io	Attending F death. ctor: Alter y the funer	atio	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No		
AME	To the Hospital or Attending Phwithin 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or A within 24 hours effer To the Funerel Direct completely filled in by	Medical		sician: To the best of my knowner: On the basis of examinating and manner stated.				s) and manner as stated. Id place, and due to the cause(s)
2	within To th compl	Me	29b. Signature and title of certifier	10 110	2	29c. License number	29d. Da	ate signed (Month, Day, Year)
	\circ		30. Narry and address of person who per	empleted cause of death (Itel	m 23a) (Type, Print)	00063296	1 Ade	ner a Loct
	r		31. Date filed (Minist PayaYear) 200	chaels Mi	St/	gres Hospita	1 900 (ato	n the Mayland
	Sta Regist		DEC'1 9' 200	6 Marie L	MANGE			357

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day LION FRANCIS 14 2006 DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth
Hours Min. Ap Mann. Dev3 Year 1931 5P27AL 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** Months Days 1**X**M 2□F 75 Director Yrs. Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examples Item Milled at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Halethorpe **Funeral Director** Baltimore 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4400 Ridge Avenue 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 1 4 48 2 2 3 48 - 48 - 445 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Joseph Kick Genevieve Gosnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Kick/ Wife 4400 Ridge Avenue Halethorpe MD 21227 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Loudon Park Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-18-2006 Baltimore, Maryland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Dicenses Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part I. Enter the disease, or comblications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOUR /Medical Due to (or as a consequence of): Examiner LECTROL 18 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tyes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate hes autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 2 NO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4.10 RES 00 1 DECEMBER, 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANNOVER STREET BALTIMO Registrar's Signature State Registrar

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32 Registral's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16,2006 DECEMBER PAUL KUBRICKY 09:01 P.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOSEPHS MEDICAL CENTER TOWSON BALTIMORE SAINT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 94 Country) NEW 080-05-4564 1**/∑/**M 2□ F 09-13-1912 YORK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD. BALTIMORE TOWSON 1 □ Yes 2 🛣 🔭 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? LEADBURN ROAD 21204 1818 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 □ No If Yes, Give Year or Dates: W W II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XX No Specify. Specify: WHITE ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY College (1-4or 5+) YEARS Elementary/Secondary (0-12) ADMINISTRATION ASSISTANT ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PAUL KUBRICKY EMILY HAVELKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 LEADBURN ROAD, TOWSON, MARYLAND, 21204 J.PATRICK KUBRICKY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEMETERY 12-22-2006 GARRISON FOREST, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD R. A. Bu -(R. G. RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR Due to (or as a consequence of) CARDIOVASCULAR THEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes XX No 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

Physician /Medical Examiner

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attending pl

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neral Director: /

within 24 hours at To the Funeral C

Medical

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

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r than "natural", or Iter the Medical Examiner

of Health and Mental Hygiene.
If item 27 is marked other than
or other traumatic event, the M

= 5 permit. Page Department of Important: If any injury or once. Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ģ Be Completed Certification: To

IF FEMALE:

26. Place of Death (Check only one)

1 ☐ Yes 2 X X	lo	Hospital: 1 ☐ Inpatient	X X ER/Outpatient	3 🗀	DOA
27. Manner of Death XX Natural 2 □ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	М	280
3 ☐ Suicide	6 ☐ Could not be determined	28e. Place of injury -	At home, farm, stree	et, fact	ory, c

ry v Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

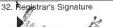
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature

29c. License number D29931 29d. Date signed (Month, Day, Year) DECEMBER 19,2006

Softperson who completed cause of death (Item 23a) (Type, Print) ST JOSEPH NED CENTER EMERGENCY DEPT. 30. Name and addre MD CHRISTOPHER BRENTE 7601 OSLER DR. TOWSON

State Registrar 31. Date filed (Month, Day, Year) DEC 1



06-09553

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

loan Kirby		For State	of Maryland	•	tment of ificate of		id Mental i		g. No.	200	1005
Physician	1	egistrar . Decedent's Name (First, Middle,La	st)					2. Date of Deat	h	Year	3. Time of Death
Medical Examine		Joan Kirby a. Facility Name (if not institution, gi	ve street and number	1	12	th City Town o	r Location of Dea	Month December		06 County of Death	0645 hrs
		St. Agnes Hospital		,		Baltimore					
Funeral Director		. Social Security Number 6. S		ge (In yrs. Ias	t birthday)	If Under 1 Ye Months Da		n.		Foreig	
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with the Maryland ms 23a or 28a-f sho be notified at once.		297 Laverne Aver	iue			2122	7		_	S. A.	ni y ?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	5	Marital Status Never Married 2 X Marrie	12. Was Deceden				spanic Origin? (Specify Yes or No- to Rican, etc.)			can Indian, Black,
ter deat	3			X No		Yes 2X N		, 5.6.,	Sc	pecify: Wh	ite
ours after a stural" xamine	2 -	15. Decedent's Education (Specify of	or Dates:	mpleted) 1	6a. Decedent	t's Usual Occupa	ation (Give kind o			d of Business/	
5-0036 ed within 72 hour tygiene other than "natu the Medical Exan	אמו	Elementary/Secondary (0-12)	College (1-4 or	5+)	,	me Make		stired)	0.77	n Home	
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121 d be fill fental F narked event,	ן מ	Eugene Urbanski 9a. Informant's Name/Relationship (10h Mailine	Address (D)	Mary Br			-	
MD 21215-0036 d 2 should be filed within 7 d 2 should be filed within 7 is marked other than numatic event, the Medica To Be Comple		dr. Steven Allen			100			Rural Route Num Halethor			
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Baltimore, permit. Pages I ar Department of Hes Important: If ite injury or other tr	L	Donation 5 Other Specify	.	Mea		ge Mem.	Park	2006		ridge,	
Bal permi Depar Impo	K	Signature of Funeral Service Lice	nsee	0147	$9 \begin{vmatrix} 22.N \\ 1 \end{vmatrix}$	Second .	sor Facility Si Avenue S	ngleton W Glen B	Fune urni	ral Hom	ne, P.A. 21061
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3760, ficate be g physici s the buri	2	FEMALE: b. Was decedent pregnant in the	23c. If yes, outco		ncy	al death 3		ancy		Date of delivery	y Day Year
Box 687 e death certific the attending p ed for use as th	2	past 12 months? Yes 2 No 9 ✓ Unknow	4 Pregnant a	t time of death	<u>, </u>	ner (Specify)		idiloy		oner E	ray Toai
D. BC	-	art II. Other significant conditions	9 Unknown	th but not resi	ulting in the ui	nderlying cause	given in Part I.	23e. Did tol	pacco use	e contribute to	the cause of death?
Division of Vital Records, P.O. tal or attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director.	2							1 Yes	2 N	lo 3 Prob	ably 4 Unknown
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Madical Contification: To Re Completed by Physician Medical Expension and Contification.		9a. Certifier 1 Certifying Physic Check only 2 Medical Examine									
,		9b. Signature and title of certifier	and manner stated			29c. Licen			29d. Dat	te signed (Mor	nth, Day, Year)
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		 Name and address of person who Ana Rubio MD. Assista 	completed cause of nt Medical Exar	,	,	treet, Baltim	ore, MD 2120)1			
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For

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-			Registrar		C	ertificate of	Death		Reg. No.	
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	Funeral			Sex 7. Ag	e (In yrs. last birthda	lf Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 9. Birtl	nplace (State or Foreign untry)
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	s 23g	rai	6500 FREETOWN R	12. Was Decedent	5	2104		- 4 4	U.S.A. 14. Race - Ame	21-20
	Her de	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	No.	Was Decedent of If Yes, specify Cub		o Rican, etc.)	Black, White	e, etc.
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Baltimore,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Dis	sposition (Name of frematory or other pla	ice)	Date	20c. Location - City or	Town, State
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alt	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Lice	ensee LIA		22. Name and Address	ess of Facility S	OL LEVIN	ISON & BROS.	, INC.
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
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O. B	the at	Physicia	1 Yes 2 No	4∏Preg <i>n</i> ant at 9□Unknown		5 ☐ Other (specify) _			Month	Day Year
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ĬŞ	r Atter de irecte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (S City or Tox	Street and Number or Ru. vn, State)	ral Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	iminer: On the basis of	f examination and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
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	10		30. Name and address of person who	completed cause of c	eath (Item 23a) (Tvo	pe, Print)			000. 10)	-
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0831AM KALISH Dac **EDWARD** 2006 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** losp. tal Baltimore -012 8. Date of Birth 12/16/1918 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 33-16-321 87 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d, Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show sr traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 TANEY ROAD 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT ACCOUNTING land; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KALISH PAULINE **FERTEL** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERTRUDE KALISH / WIFE 2503 TANEY ROAD - BALTIMORE, MD 21209 Department of Health Important: If item 27 any injury or other trong. ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 X Burial 2 □ Cremation 3 X Removal from State BETH DAVID CEMETERY 12/17/2006 ELMONT, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature permit. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immedi in Cause (Final diseas or condition resulting in death) Due to (or as a consequence of): **Physician** da /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): burial Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending posterior that the state of th IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 Probably 4 Honknown certificate has been si rector, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA ဥ 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Low

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) DEC 1

32. Registrar's Signature

P.O. Box 68760 Division or Vital Records,

Baltimore, Maryland 21215-0036

Physician /Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Medical Certification: To hours after death uneral Director: 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54352 MO DECEMBER 17 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MirceA TODOL 10 NORTHWEST HOSPITAL SYOI OLD COURT ROAD RANDALLSTOWN EEIIS am 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 🤚 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year LAWRENCE LORRAINE 8:30P M 2006 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Genesis-Loch Raven If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (Stete or Foreign Country) 1 M 2 TF 213-24-4989 75 Vrs Md. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 925 N. Broadway USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Black 3 ♥Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Avon 11th grade

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carroll Sarah Jean Molock Fred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Camper, Jr. Brother 6227 Catalpha Rd., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-20-06 Arbutus Mem. Pk. Arbutus, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East ladu Wan 21202 1101 E. North Ave., Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No 1 Tes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Md.

Funeral

Director

or items 23s or 28s-f show culture trained by notified at

permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Heelth and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Exa. Junear 9008.

Baltimore, Maryland 21215-0036

Funeral Director

Completed by

Be

death with the Maryland

Examiner Completed by Physician/Medical To Be Medical Certification;

ettending physicien and for use es the burial-transit certificete this

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funarei Director: All completely filled in by the fu

> State Registrar

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

4202 Bn

26. Place of Death (Check only one)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of dea (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2006

29b. Signature and title of certifier

1 Natural

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

2 Accident



06-09470

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Virginia Marie Leste	1- For State	tate of Maryla		artment of		d Mental I	Hygiene					
Physician/	Registrar	dle.Last)	Cei	tilicate of	Dealli	-	2. Date of Dea	teg No	3 Time of Death			
Medical Examiner	VIRGINIA MA				- Ch. Taur	Leading of Day		Day Year r 12, 2006	11001115			
	4a. Facility Name (if not institut 2613 Miles Avenue	ion, give street and nur	noer)		b. City, Town, or Baltimore	Location of Dea	ath	N/A	Death .			
Funeral Director	5. Social Security Number		7. Age (In yrs. l		If Under 1 Year Months Day		lin	,	Birthplace (State or Foreign			
Director	217-80-8964 Usual Residence of Decedent	1 M 2X F	42	Yrs			2/2/1	964	Country) MD			
r any	10a. State 10b. County	/	10c. City,	Town or Location	on			<u> </u>	10d Inside City Limits			
rland -f shov once.		I/A	BA	LTIMORE				***************************************	1 X Yes 2 No			
ith the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Number 2613 MILES AV	rent te			10f. Zip Code	211	1	0g Citizen of Wha				
h with the uns 23a be noti	11. Marital Status	12. Was Dece	edent Ever in U.		Decedent of His	spanic Origin? (Specify Yes or No)- 14. Race -	American Indian, Black,			
deat deat		Married Armed Fo	2 X No		es, specify Cubar		to Rican, etc.)	White,	etc.			
2 hours after "natural", c	3 X Widowed 4 D 15. Decedent's Education (Sp	ivorced If Yes, Give Year or Dates: ecify only highest grad			Yes 2 X No		f work done	Specify. V	VHTTE iness/Industry			
5-0036 ed within 72 hour tygiene other than "natu the Medical Exar Completed	Elementary/Secondary (0-12			during mo	st of working life			ř				
5-0036 iled vithin 77 Hygiene I other than the Medical	11TH GRADE 17. Father's Name (First, Middle	a Last)		NEVER		18 Mother's Nor	ne (Eiret Middle I	N/A Maiden Surname)				
215- be filed ntal Hyr rked of ent, the	VINCENT LESTE	,					INIA MCCA	,				
D 21 should I md Mer is mar is mar To I	19a. Informant's Name/Relation	ship (Type, Print)		10		t and Number o	r Rural Route Nur	mber, City or Town,				
- p = e a	TIMOTHY LESTER 20a. Method of Disposition	/BROTHER	20b. F		RED WOOL		E BALTII Date	MORE, MD	21234 City or Town, State			
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 Burial 2 XCrematic		III Otato	crematory or oth		TNC 12	/18/2006	CATONSI	VILLE, MD			
Baltin permit. P Departme Importan injury or	4 Donation 5 Other S 21 Signature of Funeral Service		1222	22. Na	ame and Address	of Facility T	HE JOHNS	ON FUNERA	AL HOME, P.A.			
24				1 85	21 LOCH	RAVEN E	BLVD. TO	OWSONME	21286			
Physician /Medical	Ta. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Examiner	Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a							Death			
Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of	f):								
ted Insit Examiner	cause Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a	consequence of	f):								
	events resulting in death) Last	d	consequence of	17.								
- a in in in	X UNPENDED	AMENDED	#23a,27,	perME, g8	63, 1/10/0	7T TT						
6876(certificate nding physise as the b	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		utcome of pregr rth		al death 3 [Ectopic preg	nancy	23d. Date of do Month	elivery Day Year			
Box 6876C e death certificate the attending phys ed for use as the b hysician/Me	1 Yes 2 No 9 V Ui	-	int at time of de	ath 5 Oth	er (Specify)							
Ph by th	Part II. Other significant cond	3 Ulkilo		esulting in the ur	iderlying cause g	iven in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?			
s, P.(1 Yes	2 No 3	Probably 4 V Unknown			
Records, The law require ficate has been sig. page 2 should be Completed							24a. Was autop	sy pri	ere autopsy findings available or to completion of cause of			
ician: The lactificate herector, page 2							1 🗸 Yes		ath? Yes 2 No			
Vital hysician: this certial director	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	patient 2	ER/Outpatient		of Death (Chec		Residence 6	Other Scene			
Division of Vital Records, tal or Attending Physician: The law require staffer death land prictor. After this certificate has been sind in by the funeral director, page 2 should be riffication: To Be Completed	27. Manner of Death	28a. Date o	of Injury Day, Year)	28b. Time of In	ury 28c. Injur	y at Work?		now injury occurred				
Sion Mendi death ctor: by the fi		nding estigation				res 2 No						
Division o Hospital or Attending 44 hours after death Funeral Director. After tely filled in by the fune		uld not be 28e Place ermined (Specify)	of Injury - At ho	ome, farm, street	, factory, office b	uilding, etc.	or Town, S		or Rural Route Number, City			
Hospi 24 hou Funer stely fil	29a Certifier	Physician: To the best	of my knowledg	ge, death occurre	ed at the time, da	ite and place, ar	I nd due to the caus	e(s) and manner a	s stated			
To the Hos within 24 h To the Fun completely	~ •	aminer:On the basis of and manner sta		nd/or investigation			at the time, date					
≥	29b. Signature and title of certif		>		29c. License			December 1:	(Month, Day, Year)			
	30. Name and address of perso	n who completed cause	of death (Item	23a)	3.3.1				0, 2000			
	Melissa Brassell, MD	Assistant Med	lical Examin	er 111 Pe	enn Street, B	altimore, MD	21201					
State Registrar	31. Date filed (Month Pay Year	9 2906 ^{32. Re}	trar's Signatu	re L	THE STATE OF THE S							

			1 - For State Registrar	State of Ma		partment of I		Re	g. No.	40364
ı	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Yea	
	/Medic	al	4a. Facility Name (If not institution, give	G · LAN	6	4h City Town	or Location of Deatl	Dec	4c. County of De	
	Examir	er	Howard Court	GENERAL	HOSPITAL	()			How	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthda)) If Under 1 Year	If Under 24 Hrs.			irthplace (State or Foreign Country)
	Director		213-32-2/31	M 2□F	72 Yrs.	Months Days	Hours Min.	Jan 12,	1934 Was	hington D.C.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location				10d. Inside City Limits
	Mary -1 sh	to	MD Carroll		F1.	dersburg				1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23e c	ral	101 Richards Dr	ive		217	84		U.S.A	•
	er deg	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	
36	rs aft	by F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	T71-24.
21215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f show alcal Evan Fer must be rediffed at	ted	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occup	pation	10	6b. Kind of Busines	White s/Industry
21	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5+	life.	e kind of work done DO NOT use retire	during most of wor d)	rking		
7	led w tygier her th	Cor	12			Analyst			NSA	
anc	d be findal Hed of	Be	17. Father's Name (First, Middle, Last) Kennard	G. Lang	. Cr			ne (First, Middle, Ma		G
Maryland	shouk nd Me mark matik	²	19a. Informant's Name/Relationship (7)			ling Address (Street	Celes	ste Eliza		Smith Zin Code
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-1 show any injury or other treumatic event, the Medical Examinar must be redified at 90cs.		Edith S. Lang	Wife				dersburg,		
Baltimore,	es 1 a of He of He item		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F		20b. Place of Disc			g 100 cm	Oc. Location - City of	
Ĕ	Pag ment ent: I		'4 Donation 5 Other (Specify)		-	Cemetery	12/2	1/06	Baltimor	e MD
Salt	Depart Depart Import any nj		21. Signature of Funeral Service Licens	90	1/	22. Name and Addre	•	11824 R	Reisterst	
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	Pnysician /Medical		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	aAcute		Failure		or respiratory arres	it,	Approximate Interval Between Onset and Death
8760, <	death certificate be executed e attending physician and infor use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	s	consequence of):	-V46 C	NCER			2 month
P.O. Box 6	death certifii e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnancy	,		23d. Date of do Month	slivery Day Year
	es that igned b be deta	by P	Part II. Other significant conditions con			underlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	w require been sig should b	ted	Dilated CARE	DIGMYOPA	CHTE			1 🗆 Yes	2 □ No 3 7 F	robably 4 Unknown
al Records,	The far ate has bage 2	Completed	COPD					24a. Was an autopsy performe 1 Yes 2	prior to death?	utopsy findings available completion of cause of s 2 \(\square\$ No
Vital	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	lospital:	0 T F D 10 1 11	Oth		th Check only one)		
Division of	Attending Physician: The sr death. ector: After this certificate hiby the funeral director, page by the funeral director, page	atlon; To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of	of 28c. Injury Wor	4 ☐ Nursing He y at k? Yes 2 ☐ No	ome 5 Residence 28d. Describe how		ecify)
Divis	= 0 D >	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or F State)	tural Route Number,
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical	one) 2 Medical Examil	sician: To the best of ner: On the basis of ea and manner state	camination and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the causered at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title o certifier	7	A	29c. Licens			. Date signed (Mon	
	. 0 (. 1		1-1-18	1	mp	D60	469		Dec 18	2006
	10+1		30. Name an dess of pers desco	mpleted cause of dea	th (Item 23a) (Type	, Print)	- /	LUMBIA		
	Sta	e	31. Date filed (Month, Day, Year)	705 pin 32-Registrar's	Signature	-EDOR L	AND CO	LUMBIA	MD	
	Registr		DEC 1 9 200	6	K R	and s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Lynette Estelle Coulter Lang December 13 2006 3:55 /Medical 4a. Facility Name (If not institution; give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Agnes Hospital Baltimore 8. Date of Birth (Month, Day, Year) July 28, 1 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1969 Director 214-96-6719 Rhode Island Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1X Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be n 2556 Wilkens Avenue 21223 United States Funeral tems 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status ural", or iten Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten important: If Item 27 is marked other than "natural", or Iten will plury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify þ, Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
United States 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Mail Handler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Coulter ၀ Catherine Gleaser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Lang, III - Husband 608 Warwick Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cametery crematory or other place) 20c. Location - City or Town, State Qonation 5 ☐ Other (Specify) 12-16-2006 Odenton, MD Crematory 22. Nam and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licens 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, promplications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alcohol IntoRication **Physician** day /Medical Due to (or as a consequence of) Examiner occaine ahuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trans A no xic brain Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 A No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
December \$ 13,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ragai Meana Conton Baltimore 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Coulter Lang

32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 16, 2006 **Physician** LEHEM 6:46 A M ANITA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth 5. Social Security Number **Funeral** 0371171965 1 □ M 2 👿 F 216-96-3387 41 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "nature." 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No RANDALLSTOWN BALTIMORE Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3714 BRENTFORD ROAD 21133 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygrene.

27 is marked other than "natural"

27 is a marked other than "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RHONA VENICK LEHEM ELLIOTT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 BRENTFORD ROAD - RANDALLSTOWN, MD 21133 ELLIOTT LEHEM / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State ANSHE EMUNAH AITZ CHAIM 12/17/06 HALETHORPE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service In Insee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediata Cause (Final disease a condition resulting death) **Physician** /Medical Due to (of as a consequence of) bowel 15 chem Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. **≥** 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3□ DOA Certification: To Date of Injury 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Naturai 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

within 24 hours after death To the Funeral Director: filled in by completely

> State Registrar

DHMH 17 Rev 1/2001

12

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ous 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9862 12-19-06 vt. State of Maryland / Department of Health and Mental Hygiene amend item 7 per fh g862 12620 TOGC atte of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Irene Margaret MacDonald 2. Date of Death 3. Time of Death Month Margaret Male Donald December 2006 3:00 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Marineer Health Care of Laurel Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2√□ F 99 577-01-1988 Sept, 26, 1907 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Prince Georges 1 ☐Yes 2 ☐ No Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11421 Van Dusan Road 20707 United States America 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William McClellan Susan E. Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathleen Loving / Daughter 274 Fathom Loop # 131 Beverly Hills, FL 34465 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Deurial 2 □ Cremation 3 □ Removal from State Gates Heaven Cemetery 12/11/ 2006 Silver Spring, Maryland 4 □ Donation 5 Ø Other (Specify) 21. Signal Final Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Rd. Will Laurel, MD 20707 E 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALTHERMERS YEARS Due to (or as a consequence of) Sequentially list conditions, if any serior in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 WNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

/Medical Examiner Examine the burial-trai Physician/Medical for þ Be Completed page 2 Medical Certification: To after death filled in by the e Funeral within 2

Physician

/Medical

Funeral Director

Completed by

Be ပ

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. The Medical Experiments

Maryland 21215-0036

Baltimore,

State Registrar 29a Certifier

death

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8317 A. CASAS CHIRRY LANE VAULER UIT LUIS

and manner stated.

32. Registrar's Signature 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Albert May, Sr. 12:52 a^M 18,2006 /Medical December. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3504 Greenvale Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/02/1932 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-30-9168 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Baltimore 1 **X**Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 Greenvale Road 21229 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If then 27 Is marked other than "natural", or items 23a any holivy or other traumatic event, the Medical United States Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2X No Specify. þ SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician Dental Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert May Catherine M. Cocnavitch 2 19a. Informant's Name/Relationship (Type. Print) Helen K. May / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Greenvale Road, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Cedar Hill Cemetery 12/22/06 Brooklyn Park, Maryland 4 Denation 5 ☐ Other (Specify) 21. Schatule of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) CONGESTIVE 8 YEARS /Medical Due to (or as a consequence of): Examiner 15CHEM. C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed MYOCARDIAL YEARS and trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the irector, page 2 s perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Medical Certification: To To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 18, 2008 00025844 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTAS L. COMMERCO CO, MO 5411 OLD MILOCLICE LO MIF 82. Registrar's Signature State Miles Collans Registrar

			1 - For State Registrar	State of M	1arylan		artment o			and M		giene () Reg. No.	06	403	69
	Physici		1. Decedent's Name (First, Middle, L RUSSELL Wayne								2. Date of Dea Month	Day	Year 2006	3. Time o	f Death
	/Medio Examir		4a. Facility Name (If not institution, git Baltimer VA)	ve street and number			4b. City, To Bait				December	4c. Count	y of Death	L.D	
	Funeral Director		5. Social Security Number 6.			ast birthday) Yrs.	If Under 1		If Under 2 Hours		8. Date of Birt. (Month, Day 6-29	h /, Year)	-	ace (State of	-
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920	urs after dea el', or Items Executier o	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 XI Yes 2 If Yes, Give Year or Dates	s?] No		Was Deceder If Yes, specify		panic Orig , Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americack, White, of		
Maryland 21215-0036	J within 72 hours Jiene. Ir then "neturel", Ine Madical Ext	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)		r 5+)	(Give	dent's Usual (kind of work of DO NOT use	done du		of worki	ng	16b. Kind of E	Business/Ind	ustry	
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Mar	S D E E		19a. Informant's Name/Relationship Ethel M. Mosby	(Турө, Print) Wife	2		-				<i>l Route Numbe</i> ltimore	•	, State, Zîp 21218	Code)	
	m Q L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. P	Lace of Dispo emetery, crer	sition (Name natory or othe	of er place)	}	C	Date	20c. Location			
Baltimore,	# 문 원 등 .		* 4 Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Ga		Fores Name and		1		1-06 March F		s Mil.	ls, Mo	J.
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	Pnysician /Medical Examiner		23a. Part1. Enter the disease, of cor shock, or heart failure. List on! Immediate Cause (Final disease or condition resulting in death)	aSh	line.	2	er the mode o	or dying,	such as	cardiac o	r respiratory an	rest,		Approximal Interval Bet Onset and	ween
8760,		sai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause Disasse of hiu y that initiated events resulting in death) Last	b. Due to (or a		,									
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۵.	The law requires that the ite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying cau	se given	in Part I.			bacco use con		e cause of c	
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Vita	Physicien: this certificaral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		5B/0.4-4		Other	1199-1		(Check only or		(2)		
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Division	in Direct	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of I	njury · At ho etc. (Specify	me, farm, str	eet, factory, o	office		2	28f. Location (S City or Tow		ber or Rural	Route Num	ber,
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)	To the I	Me	29b. Signature and title of certifier	·/-	MD			icense i		K140		29d. Date signe Decem			0/0
4	12		30. Name and address of person who		death (Item		Print)			. 1	1,000	, , , , , , , , , , , , , , , , , , , ,	- 4	11166	, July
	Sta Registi		31. Date filed (Month, Day, Year)	32 negis	itrar's Signal	MARC	arles	~(<i>~</i>						

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of M	arylan		artment rtificate				F	Reg. No.	006	403	71
26.	Physici	an	Decedent's Name (First, Middle, L.	ast)							2. Date of Dea Month	ith Day		3. Time o	
2 7	/Medic Examir	cal	Jean Dolore: 4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location		Dec 16	7-	2006 County of Dear	6:30	A M
- 48			7028 Woodbine R	oad	. //	for a birth of a li	WOOO If Under	bine	If Under	24 Hrs	0. Dota of Rist		Carroll	thplace (State	or Foreign
j.	Funeral Director			Sex 7. Ag 1 ☐ M 2 □xF		last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Jan 9	, _{Year)} 1936	Co	cyland	or roreign
			Usual Residence of Decedent		70	y, Town or Lo								10d. fnside C	Titu Limite
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	28a-1	rect	MD Carrol 10e. Street and Number	<u> </u>] WC	XXXXIIE	10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	h with	Funeral Director	7028 Woodbine Ro	ad				2179	97				US		
	r deat	ner	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Deced	lent of His	spanic Or n, Mexica	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Iteme 23s or 28s-f show or other traumatic event, the Maultal Exabilizational Le huiffied at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ ff Yes, Give X Year or Dates:	No		1 ☐ Yes	2₩ No	Specify.	•			Specify:	White	
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e,	1 and lealth lm 27 ther to		Bruce Moore 20a. Method of Disposition	son	20b. F	7028 Place of Dispo	Woodk		Road		odbine	MD 20c. Lo	21797 cation - City or	Town, State	
Jor	ages nt of h t: ff ite		1 ☐ Burial 2 ☐ Cremation 3			cemetery, cre ne Grov	matory or o	ther place		Dec 1	19 2006		. Airy	MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tre once.		4 Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic		1	2:	2. Name an	d Addres	s of Facil	ity Bur	rrier-Q	ueen	Funera		
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of \	Phys this ai dir	2	1 ☐ Yes 2 ☐ No 27. Mann → Death	Hospitaf: 1 ☐ Inpati		ER/Outpatie		Othe 28c. Injury	4 U N		ne 5 Resid		6 □Other (Spe	ecify)	
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	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier	and manner s	1				e number			29d. Da	te signed (Mon	th. Day, Year)	
	- s + 5		1	om (Mal	1 N	10		100	599	43		Dec	emise	1812	2006
10	1		30. Name and address of a son wh	o completed cause of	death (Ite	m 23a) (Type	, Print)	5 / 6		7	2-1	245	/ NA: -	- 110	_
U	Color Color		31. Date filed (Month, Day, Year)	32/Regist	rar's Sinn	ature		7017	- >		الساد	1)	110	2(1)	/
	St Regist	ate rar	DEC 1 9	2006	iai a siyri	H. Ag	asks								

			1 - For State of Maryland /	Department of Health and Mental Hygiene Certificate of Death Reg. No. 106 40372
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) CharLES R. MANGUM 4a. Facility Name (If not institution, give street and number)	2. Date of Death Month Day Year 13. Zoo'6 8.30 Am 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director	CI.	26 GIENWOOD RD. 5. Social Security Number 6. Sex 7. Age (In yrs. last b.) 461-46-4648 18M 20F 7.	ESSEX BALTIMORE
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town AD BALTIMORE ES	wn or Location 10d. Inside City Limits
3	ns 23a or 28	Funeral Director	10e. Street and Number 26 CIENUCOD R 11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 10g. Citizen of What Country? 2 2 2 3 5 A - 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
9600	tural, or Iter		1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Black, White, etc. Specify: White, etc. 1 16b. Kind of Business/Industry
21215-0036	illed within 72 hours after beath with the Maryland Hygiene. Inthe then "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired) LECTRICIAN CHEMICAL CO.
arylan	should be fit and Mental H Is markad ott sumatic evan	To Be	17. Father's Name (First, Middle, Last) WillE H. MANGUM 19a. Informant's Name/Relationship (Type, Print) 19	18. Mother's Name (First, Middle, Maiden Surname) Lillian R. SingleTon 1b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ore,	es 1 and 3 of Health itam 27 r othar tr		20a. Method of Disposition 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Name of ery, crematory or other place) MY CAFT REASTRY 17-15-06 HANDER MOR
Baltii	permit. Page Department. Important: It any injury o		21. Signatura of Fundral Pervice Licenses	22. Name and A. dress of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122
	nysician /Medical		23. Part . Enter the disease, of complication that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ee Conset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Mesofice Due to (or as a consequence Cause (Disease or injury that initiated events)	a of):
	cate be executed physician and the burial-transit	Ical	resulting in death) Last Due to (or as a consequence d	ə of):
. Box	that the death certifica ed by the attending ph detached for use as the	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day Year
۵.	The faw requires that the take has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Homknown
		Completed	25. Was case referred to medical	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
o	After After funer	tion; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O 27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq seidence 6 \subseteq Other (Specify) Time of Injury M
Division	deal deal ctor: y the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or within 24 hours after To the Funaral Director completely filled in b.	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
ł	K		30. Name and address of person who completed cause of death (Item 23a)	29c. License number 29d. Date signed (Month, Day, Year) 12/1406 (Type, Print) 11ARD POSEDNIE, MD. 21237
	Sta Registr		31. Date filed (Month, Pay, Year) 32. Agistrar's Signature DEC 1 9 2006	Section (E) MD. Z(Z37

				ype or Print in Black Inc State of Maryland / Depa		•		
			For State Registrar		tificate of Death	Reg.	711116	40373
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Mary Frances Mo	CNeir		2. Date of Death Month December	r 7,2006	3. Time of Death 4:15P M
	Examin		4a. Facility Name (If not institution, give s Stella Maris Nu		4b. City, Town, or Location of Death Timonium		4c. County of Death Baltimon	re
	Funeral Director		5. Social Security Number 6. Sex 216-24-2255	M 200 F 7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aprill,	9. Birthpi Coun 1926 Mary	lace (State or Foreign try) 7 land
	show det	ľ	Usual Residence of Decedent 10a. State 10b. County MD Baltimor	10c. City, Town or Lo				Od. Inside City Limits
40.00	or 28a-f	Olrecto	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	1 ☐ Yes 2 ☑ No try?
1215-0036	perint. Fagos I and 2 should be fred whitely for thous arise beauth with the maryren perint in the theath and Mantal Hydiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be natified at ODEs.	by Funeral Director	2300 Dulaney Va 11. Marital Status 1 Newer Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?	21093 Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puert	pecify Yes or No- pecify Rican, etc.)	USA 14. Race - America Black, White, 6	etc.
-003c	atural, o	ted by	3 Widowed 4 □ Divorced 15. Decedent's Educ	If Yes, Give Year or Dates:	☐ Yes 2 No Specify:	16b	Specify.Whit	
21212	giene.	Completed	(Specify only highest grade	College (1-4or 5+) 4 College (1-Var 5+) Vult	kind of work done during most of wor 20 NOT use retired) CSE		. Joseph	s Hospita
Maryland 21215-0036	Mental Hy riked oth	To Be C	17. Fathers Name (First, Middle, Last) Edward Francis	Dunn		ne (First, Middle, Maid		-
Mary	alth and h		19a. Informant's Name/Relationship (\mathcal{T}_{yy}) Mary T_{\bullet} Country	pe, Print) 19b. Mailin rman-Daugh. 14010	g Address (Street and Number or Ru) Glen High Rd.	ral Route Number, Cit Baldwin	ity or Town, State, Zip	Code) 13
Baltimore,	ent of He nt: If item ry or othe		20a. Method of Disposition 1 M Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	amoval from State	natory or other place)		Location - City or To	
Balti	Departm Departm Importa eny inju		21. Signalus of Tuyleral Service License	le / 22	Percerui Friter	natives	Funeral&	Crematic
	hysician /Medical xaminer		23a. Part / Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not ente e cause on each line.	er the mode of dying, such as cardiac		•	Approximate Interval Between Onset and Death
10	*	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
ba/bu, ~	physicien and the burial-tran	Ω	that initiated events resulting in death) Last	Due to (or as a consequence of):				
YOU .	ed by the attending physical detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	ry Day Year
r i	been signed b	þ	Part II. Other significant conditions con	tributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacc	2 No 3 Proba	e cause of death? ably 4 Unknown
		Completed				24a. Was an autopsy performed 1 Yes 2 1	prior to con death?	sy findings available apletion of cause of
VII	certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 DNo	ospital: 1 Inpatient 2 ER/Outpatient	104	th Check only one		
VISION OF VITA	th. : After this s funeral d	-	27. Manner of Death 1 Valural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	e 6 ☐Other (Specify njury occurred)
		Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural late)	Route Number,
9	within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as sta and place, and due to	aled. the cause(s)
	To the	M	29b. Signature and title of certifier Cumpanasacc	0	29c. License number 016619		Date signed (Month, D	

State Registrar CORAZON VERGARA-SOARES, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093
31. Date filed (Month, Day, Year)
DEC 1 9 2006

PROGRAMONIUM, MD 21093

			1 - For Amend #17&1 Registrar		G863 1/	05707 Cert	ificate o	r Health of Death	and M	ental Hy	/gien Reg. N	e •2006	40371
*	Physici /Medi		1. Decedent's Name (First, Middle, L Clarence Thoma	,						2. Date of De Month Decemb	D	17, 2006	3. Time of Death 8:20 P M
	Examir	ner	4a. Facility Name (If not institution, g Stella Maris Hos	spice)		4b. City, Town	ium				County of Deat	h
	Funeral Director		5. Social Security Number 218–28–4188 Usual Residence of Decedent	Sex 7. A 1 M 2 □ F	ge (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Da	ar If Unde ys Hours	Min.	8. Date of Bir (Month, Da Februa	rth ay, <i>Year</i> ry2,	9. Birt 1933 Ba	hplace (State or Foreign untry) Ltimore, MD
	Maryiand I-f show fied at	tor	10a. State 10b. County		10c. City, To	own or Loca							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 203 S. Ellwood Av	enue			10f. Zip Cod 2122				10g. C	itizen of What Co	untry?
5 p.m.	be filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ▼Yes 2 ☐ If Yes, Give Year or Dates:	? I No		as Decedent of Yes, specify O			cify Yes or No Rican, etc.))-	14. Race - Amer Black, White Specify Whit	e, etc.
7:45 p.	d within 72 h giene. er than "natu the Medica	Completed by	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12		F.)	(Give ki life. DC	nt's Usual Oco nd of work do NOT use ret Or Of F	ne during mo. ired)		g	4.1	Gind of Business/I	•
2006 yland	be do do	To Be C	17. Father's Name (First, Middle, Las	Miller Cla	arence	Franc	is Mil	18. Moth	er's Name ela W	(First, Middle Vindsor	, Maidei	seline Ma	ary Windsor
7, Mar	nd 2 alth a 27 is r tra		19a. Informant's Name/Relationship Marlene Miller-	(Type. Print) Spouse	1 2	9b. Mailing 203 S.	Address (Stre	et and Numb	er or Rural	Route Numb	er, City	or Town, State, Z MD 2122	ip Code) 4
CEMBER 1 Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control		20b. Place ceme Evans	of Disposit tery, crema Funer1	ion (Name of tory or other p Chapel/	_{lace)} Belair	12/20			ocation - City or	,
DECEMBER Baltimor	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice					0000	^{ty} Chap Harfo	el and rd Rd.	Fai	emation :	Services- MD 21234
	Physician /Medical		23a. Partl. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. CONGEST:	iiie.	RT FA		ying, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner but but but but but but but but but but	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequenc	e of):							
68760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a consequenc	e of):							
Box 6		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		ctopic pregnar					23d. Date of deliv	very Day Year
MILLER rds, P.O	requires that een signed b	ed by PI	Part II. Other significant conditions	contributing to death b	out not resulting	in the unde	erlying cause (jiven in Part I					the cause of death?
CLARENCE MI Vital Records	The la ate has page 2	Completed										prior to co	opsy findings available ompletion of cause of 2 ☐ No
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:				Ale e e		Check only o			
on or	ding Phys h. After this funeral dir	\vdash	27. Manner of Death 1 Natural 5 □ Pending	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28b.	Time of Injury	28c. Inj	ury at ork?	28	e 5 ☐ Resid			MOSPICE
-	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of inju	ury - At home, i c. <i>(Specify)</i>	farm, street		Yes 2		f. Location (S City or Tow	treet an n, State	d Number or Run)	al Route Number,
	the Hospital	Medical	29a. Certifier (Check only one)	nysicfan: To the best niner: On the basis of and manner sta	t examination a	ge, death o	ccurred at the tigation, in my	time, date an opinion, dea	d place, an	d due to the o	cause(s)	and manner as s I place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Ě	29b. Signature and title of certifier					ise number	15	2		e signed (Month,	Day, Year)
*	Q		30. Name and address of person who		,		nt)					410/00	
	Stat Registra	.~	DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year) DFC 1 Q	32. Registra	LANEY V ar's Signature	ALLEY	RD.	TIMON1	UM, M	D 2109	3		

DHMH 17 Rev 1/2001

	_	State Registrar			i Marylai			of Health and I of Death	Ra	g. No.	006	40375
Physicia /Medica Examine	al	1. Decedent's Name Virginia 4a. Fecility Name (If r.	not institution, giv	Rose e street and nur	n <i>ber)</i>	furphy		wn, or Location of Death		16 4c. Cou	2006 unty of Death	3. Time of Death OB: 25
uneral irector		5. Social Security Nur 004–16–801	mber 6. S		7. Age (In yrs.	. last birthday)	If Under 1			Year)		place (State or Fore
r 28a-f ahow Incilling at			Decedent 10b. County Anne Aru	ndel		ity, Town or Lo						10d. Inside City Lim 1 ☐ Yes 2🏋
23e or 28	al Dire	10e. Street and Numb		ve	·		10f. Zip Co		10	g. Citizen	of What Cou	intry?
유를	by Funeral Director	11. Marital Status 1 □ Never Married 3 ◯ Widowed 4		12. Was Dece Armed Fo 1\(\) Yes If Yes, Giv Year or D	2 □ No		Was Decedent If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specify:</i>	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White, ecity: Wh	
in "natur Mudical	Completed	(Specify Elementary/Second	15. Decedent's Edy only highest gra	ducation ade completed) College (1	-40r 5+\	16a. Dece (Give life.	dent's Usual C kind of work of DO NOT use	Occupation done during most of wor etired)	rking	6b. Kind o	of Business/In	ndustry
등등 등	Be	17. Father's Name (F.		3_		Nurse			ne (First, Middle, M	Medi Maiden Sun		
a marke	၉	William N 19a. Informant's Nam			aughter	19b. Mailii	ng Address (S	Kathlee		City or To	wn, State, Zij	p Code)
item 27 other t			sition		20b.	_	and the second second second	rs Ridge Co	Date 2			
important: If eny injury or once.												ne, P.A.
sician ledical aminer		shock, or heart Immediate Cause (Fi disease or condition resulting in death)		a. Chr	ach line. Onic (O BSto	. 44	f dying, such as cardiad	۵.			Interval Between Onset and Death
cien and ourial-transit	cal Examiner	Sequentially list condition any, leading to immicate. Enter Underly Cause (Disease or in that initiated events resulting in death) La	jury	b. Due to (or as a consector as	quence of):	uch ve	Pulmonar	y Viser	**E		
ettending physicien and for use as the burial-transit	ca	that initiated events	oregnant control	b. Due to (c. Due to (d	or as a consector or as a consector of pregnirth 2 ☐ Fettant at time of contents.	quence of): quence of): ancy al death 3 [□Ectopic pregi	nancy	y Viser		Date of deliv Month	ery Day Year
gned by the ettending physicien and be detached for use as the burial-transit	by Physician/Medical	Cause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2	oregnant onths?	b. Due to (c. Due to (d	or as a consection as a consection of pregnith 2 Fet and at time of cown	quence of): quence of): quence of): ancy al death 3 [death 5 [⊒∈ctopic pregi] Other (speci	nancy fy)		23d.	Month	Day Year
ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent print the past 12 mr. 1 Tys. 2 9 Unknown Part II. Other signific	oregnant onths? No	b. Due to (c. Due to (d	or as a consection as a consection of pregnith 2 Fet and at time of cown	quence of): quence of): quence of): ancy al death 3 [death 5 [⊒∈ctopic pregi] Other (speci	nancy fy)	23e. Did tobe	23d. acco use c s 2 Ne	Month contribute to to 3 Prot	bably 4 Unknown
certificate has been signed by the ettending physicien and rector, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Lause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent properties in the past 12 mm 1	oregnant conditions of the medical	b. Due to (c. Due to (d	or as a consection as a consection of pregnith 2 Fet and at time of cown	quence of): quence of): nancy al death 3 [death 5 [⊒∈ctopic pregi Other (speci indertying caus	nancy fy) se given in Part I. 26. Place of Dea	23e. Did tobe	23d. acco use c s 2 No	Month contribute to to o 3 Prof 4b. Were autoprior to codeath? 1 Yes	Day Year the cause of death? bably 4 Unknow posy findings availat mpletion of cause of
ler this certificate has been signed by the ettending physicien and neral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Cause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 9 □ Unknown Part II. Other signific 25. Was case referre examiner?	oregnant conditions of the medical	b. Due to (c. Due to (d	or as a consection as a consection as a consection as a consection and a consection and at time of cown seath but not resignate the consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection and a consection as a consection and a consection	quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u EF/Outpatier 28b. Time o Injury	□Ectopic pregi □ Other (speci underlying cause nt 3□ DOA f 28c.	26. Place of Dea Other: 4 \(\text{Nursing H} \) Injury at 1 \(\text{Vork?} \) 1 \(\text{Yes} \) 2 \(\text{No} \)	23e. Did tob: 12 Yes 24a. Was an autopsy perform 1 Yes 22	23d. acco use c s 2 No ed? No loce 6 No winjury oc	Month contribute to to a 3 Protection Prote	Day Year the cause of death? bably 4 □Unknow opsy findings availat impletion of cause of 2 □ No
ler this certificate has been signed by the ettending physicien and neral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Cause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent properties of the past 12 mg 1 yes 2 yes 2 yes yes 2 y	oregnant onths? No ant conditions of to medical of the conditions of the conditions of the conditions of the conditions of the condition of th	b. Due to (c. Due to (d	or as a consection as a consection of pregnicity of the consection	quence of): quenc	Decoursed at the occurred at t	26. Place of Dea Other: 4 \(\text{Nursing H} \) Injury at 1 \(\text{Vork?} \) 1 \(\text{Yes} \) 2 \(\text{No} \)	23e. Did tobing the second of the total control of the control of	23d. acco use c s 2 No ed? No ece 6 No eset and Nu State)	Month contribute to to a 3 Protection Protection Protection Service Protection Protecti	Day Year the cause of death? bably 4 Unknow opsy findings availat impletion of cause of 2 No fy)
in a fund and are received. After this certificate has been signed by the estending physicien and the Fundral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Cause (Disease or in that initiated events resulting in death) La IF FEMALE: 23b. Was decedent print the past 12 mg 1 Ves 2 g Unknown Part II. Dther signific 25. Was case referre examiner? 1 Yes 2 N 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	oregnant onths? No ant conditions of investigation determined Cartifying Ph	b. Due to (c. Due to (d	or as a consection as a consec	quence of): quenc	Dectopic pregion of the course	26. Place of Dea Other: 4 Nursing H Injury at 1 Vork? 1 Yes 2 No	23e. Did tobe 24a. Was an autopsy perform 1	23d. acco use c s 2 No ed? No ed 6 0 nce 6 0 vinjury oc est and Nu set and plat d. Date sig	Month contribute to to o 3 Protection Properties 4b. Were autoprior to condeath? 1 Pes Other (Special Courred) I manner as since, and due to gned (Month,	Day Year the cause of death? bably 4 Unknow Dopsy findings availate Impletion of cause of 2 No No No No No No No No No No

DHMH 17 Rev 1/2001

Murphy, ViaginiA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 04:30AM **Physician** 2006 Myers December 18 Lorraine Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Balti more N/A Sount Agnes Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) Aug. 11, 1923 Mary Land 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days 1 ☐ M 2 🔀 F Yrs Aug. 83 217-12-3816 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Catonsville 1 ☐ Yes 2 No Baltimore Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 63 Gardenridge Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married White 1 ☐ Yes 2K No Specify: Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Department Store Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Health and Menta em 27 Is marked Williams James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
63 Gardenridge Rd., Catonsville, MD 21228 19a, Informant's Name/Relationship (Type. Print) Lloyd E. Myers (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or of once. Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 12/22/06 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen-3620 Wilkens Ave., Baltimore, MD 21229 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) non Retotic Acidosis Hypero Smolar 1 day **Physician** /Medical Gastrointestinal bleeding Examiner A cute Upper Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed aftending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) 1□Yes 2No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Multiple Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 2 X No Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital c within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December, 18, 2006 P18617 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

900 s Coton Avenue

Baltimore M 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			State of Maryland / Depart		Mental Hygi	ene	1 0 0 0 54
			Registrar 1. Decedent's Name (First. Middle. Last)	ificate of Death	2. Date of Death	g. No.	40377
П	Physici		,		Month	Day Year	3. Time of Death
· ÿ	/Medic Examir		Frances A. Martin 4a. Facility Name (If not institution, give street and number) 4	4b. City, Town, or Location of Deat	December	15, 2006 4c. County of Death	1:55 A ^M
			6706 N. River Drive	Middle River		Baltimore	
	Funeral		1 DM 2 DE	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		215-30-4650 Tusual Residence of Decedent		Mar. 12,	1934	Maryland
	yland Iow at		10a. State 10b. County 10c. City, Town or Locat	tion			10d. Inside City Limits
	e Mar a-f st tiffed	ctor	MD Baltimore Middle Rive	er			1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	s 23a nust I	ral	6706 N. River Drive	21220		JSA	
	ter de item	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	as Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
980	urs al	þ	3 ☐ Widowed 4 ☐ Privorced Year or Dates:	Yes 2 (No Specify:		Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give kin	nt's Usual Occupation	rking 1	6b. Kind of Business/Ir	
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	be filed within 72 hours after death with the Marylan tal Hygione. Id alt Hygione. Id other than "natural", or items 23a or 28a-f show of event, the Medical Examiner must be notified at	°C°	12 Manager		ne (First, Middle, Ma	Citicorp	
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ary	shou and M s mar	Η.		Address (Street and Number or Ru		City or Town, State, Zij	Code)
Σ.	and 2 ealth n 27 i			ce Ridge Court;	Monkton,	MD 21111	
more,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic edone.		I K Buriai 2 U Cremation 3 U Removal from State	ion (Name of tory or other place)	Date 20	0c. Location - City or To	own, State
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, =	Physician	i (i	Immediate Cause (Final		1	3	Interval Between Spinset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	35east C	uncer	-	3 months
3.	Examiner	L	Sequentially list conditions, b.				
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58760,	ficate be executed physician and is the burial-transit	edical	d				
	rtifica ng ph	Medi	IF FEMALE:				
Вох	seath certifi attending	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ed	ctopic pregnancy		23d. Date of deliver	ery Day Year
0	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Ol 9 ☐ Unknown	ther (specify)		World	Day Teal
J.	The law requires that the death certified has been signed by the attending age 2 should be detached for use a		Part II. Other significant conditions contributing to death but not resulting in the unde	erlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Records,	w requires that been signed to should be deta	ed by			1 ☐ Yes	25 No 3 Prot	pably 4 □Unknown
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Vita	clan: ertific actor,	Be (25. Was case referred to medical examiner?		th Check onl one		
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o	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M _1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division or	I or Attend after death Director: do in by the f	ifica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street,			et and Number or Rura	al Route Number,
ב	tal or s afte al Dir ed in	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: within 44 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to		29a. Certifier Check on Embedding Physician: To the best of my knowledge, death or check on Embedding Physician: To the basis of examination and/or investigation.	ccurred at the time, date and place stigation, in my opinion, death occu	, and due to the cau	ise(s) and manner as s	tated.
	thin 2 thin 2 the l	Medical	and manner stated.			I. Date signed (Month,	
	F 7 F 8	_	298. Signature and title of carther	Dan 560	119	12/15/	66
•	1 -		30. Name and address of person who completed gause of death (Item 23a) (Type, Prin	nt)	1 (/ - /	`
	V		Robert B. Donegan, M.D. 6569 N. Char	les St.; Towson,	MD 21204		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	acti			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Wear 2006 **Physician** 10:45PM JOHN H. MUHLY, Jr. -4e Facility Name (If not institution, give street end number) DEC /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Multi Medical Baltimore Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1⊠ M 2□ F Months Hours Yrs. 719-18-5866 Director Sept 11, 1917 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinar must be notified as Md. Carroll Westminster 1 ☐ Yes 2 🖾 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21158 1305 Uniontown Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Mechanical Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health end Mantal Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be John H. Muhly, IV Louise Ortell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 829 Kingston Road Baltimore, Md. 21212 Mr. Kent Muhly/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemner Cem. 12-21-06 Baltimore. Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funer | Fervice License 1050 York Rd. Towson, Md. 21204 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final diseese or condition resulting in death) GLIO BLASTOMA MULTI FORME Monog Examiner Due to (or as a consequence of): Examiner DEMENTIA physicien end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c. as a consequence or, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Š 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed LUNG CANCER 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 27. Menper of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours effer death. To the Funeral Director: After th complataly filled in by tha funere Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760.

State

edicai

29a. Certifier

29b. Signature and title of certifier

d Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

DEC 1500 2006

Suple MO D0053150

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Shalcunmaca Gupta 9650 SANTIAGO RD

SUITEITO COLUMBIA MO 21045

31. Dete filed (Month, Day, Year) 32. Registrar's Signature

2006 Degua

DHMH 16 Rev 6/95

Registrar

29c. License number

			For State Registrar	, ,				d / Dep		t of H	lealth a	and M	fental Hyg		2006		40379
			Decedent's Name (First, Middle)	, Last)	-								2. Date of Dea	th			3. Time of Death
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	Examin		4a. Facility Name (If not institution,	give s	treet and nur	nber)			4b. City,	Town, or	Location	of Death			. County of De		
			GREATER BALTIM	IORE	MEDIC	CAL	CENT	ER		owso]	BALTIMO		
	Funeral Director		5. Social Security Number 218-26-0708 Usual Residence of Decedent	6. Sex	M 2∑ F	-	(In yrs. 12 74	ast birthday Yrs.	Months		If Under Hours	Min.	8. Date of Birth (Month, Day Feb. I	Year)	1932	irthpla Co <i>untr</i>	ce (State or Foreign y) MD •
	and		10a. State 10b. County				10c. City	, Town or L	ocation							100	d. Inside City Limits
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Baltimore,	Pages nent of h int: If ite iry or of		1 ☑ Burial 2 ☐ Cremation 4 ☐ Dongation _ 5 ☐ Other (Sp.		emoval from	State	Gre	eek 0	position (Nar ematory or o rthodo	X Ce	e) em.		6/2006		lood law		
Balti	permit. Pages Department of I Important: If its any injury or of		21. Signature of Juneral Service L	icense	9								k Towsor son, Mar				e, inc.
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	/Medical Examiner		resulting in death)		Due to	or as a	copsequ	ence of):		-							
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) Box 6	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23	3c. If yes, out				□Ectopic pr	egnancy	,				23d. Date of c		v Day Year
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	6	W	30. Name and address of person	who cor	mpleted caus	e of de	ath (Item	11.	e, Print)	1	2 -/	1.	Aluth	-7	T. 1/00 4	11	21204
	Sta	ite	31. Date filed (Month, Day, Year)	11	0 J J	egistra	r's Signat	ure	NOONES	1	41/1	ion,	101/11	/	OWSUN	M	V
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 A M 1:45 Dec. 14, Robert Noppinger /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Edenwald Towson Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Jan 1 8, 1927 Maryland 1**火** M 2□F 79 220-18-9177 Yrs. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 TYes 2 No MD Baltimore Towson Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21286 800 Southerly Road, Apt 402 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 145–47 12 Yes ≥ □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 10 White 1 ☐ Yes 2 ☐ No Specify. ò 151-153 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Churchill/McKesson than the M Elementary/Secondary (0-12) College (1-4or 5+) Salesman Distributors 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irmengard Μ. Baumann Michael Noppinger ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 800 Southerly Rd., Towson, MD 21286 Department of Health a Important: If item 27 is any Injury or other tra Mary Alice Noppinger-wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Hilltop Srv Corp. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/18/06 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Du to (or as a consequence of): INPARCILON 172 /Medical Examiner OISHIME nninoscuinon (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 TYes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 25 NO 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After 1 n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu within 2

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

3altimore, Maryland 21215-0036

5 Pending investigation 1 Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar 101m

CADE LIEWII

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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			1 - For State Registrar		State of N	1arylar	•	artment <i>rtificate</i>		lealth and Death	Mental Hy	/giene Reg. No./	2006	1.0381
			Decedent's Nam	e (First, Middle,	Last)						2. Date of D	eath	.000	3. Time of Death
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	Examin		,	·	give street and number	r)		4b. City,	Town, o	r Location of Deat	h	4c. C	County of Dea	ath
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after	or ite	Fu	1 Never Marı	ried 2 🔀 Marrie	Armed Forces and 1 ☐ Yes 2√	X No		If Yes, spec 1 ☐ Yes 2			to Rican, etc.)		Black, Whi	
	ural", I Exa	d by	3 Widowed		If Yes, Give Year or Dates	:							Specify: Wh	
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	other other vent,	BeC	17. Father's Name				1			18. Mother's Na	me (First, Middle	e, Maiden S	Surname)	
a yian 4 14 15-0000	Menta arked aric e	70	Raleigh	O'Dell						Nina H	olloway			
2 sho	ism ism raum		19a. Informant's N	ame/Relationsh	ip (Type. Print)					and Number or R				
t and	f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exa <u>miner must be notified at</u>		Linda O' 20a. Method of Dis	-	fe	20b. F	7321			Mills Ro	ad, Col			
ades 2	t: If its		1 ☐ Burial 2	□ Cremation	3 □Removal from Stat	(θ) ¦	Date 20c. Location - City or Town, State (16/2006) Odenton, MD							
į	Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once.		21. Signature of Fi	5 Other (Spuneral Service L		, we	st Aru			ss of Facility Do				
	Depar Impor any ir			OMEC	2 A Mark	M0110				tt Avenu				
			23a. Part1. Enter	he disease, or our dark failure. List o	complications that cause only one cause on each	ed the deat line.	th. Do not en	ter the mode	of dyin	ng, such as cardia	c or respiratory	arr <i>e</i> st,		Approximate Interval Between
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es tha	gned be det	by P	Part II. Other signi	ficant condition	ns contributing to death	but not res	sulting in the u	ınderlying ca	use giv	en in Part I.				o the cause of death?
requir	een si Iould										1	Yes 2□	No 3□P	robably 4 nknown
N N	has b e 2 st	Completed									24a. Was	ppsy	prior to	utopsy findings available completion of cause of
<u>ר</u>	icate r, pag		05.111								1□ Yes	- 1	death? 1 ☐ Ye	s 2 No
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5 A	er this eral d	n: To	27. Manner of Dear	th	28a. Date of In	jury	28b. Time o		Bc. Injur Worl		forme 5 Res 28d. Describe			edry)
i i	ath. or: Aft he fun	atio	1 Naturai 2 Naccident	5 ☐ Pending investiga	ation	ay rear	Injury	M		Yes 2 □ No				
or Att	ter de irecto n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6	and Zoe. Place of it	njury - At he etc. <i>(Specil</i>	ome, farm, sti fy)	reet, factory	office	-	28f. Location City or To	(Street and own, State)	Number or F	lural Route Number,
oital C	eral D		29a. Certifier	1 Certifying	Physician: To the bes	et of my kno	wledge dest	th occurred	at the tir	mo data and place	and due to the	2 001150/5)	and manner o	s otated
e Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)	2 Medical E	xaminer: On the basis and manners	of examina	ation and/or in	vestigation,	in my o	ppinion, death occ	urred at the time	e, date and p	olace, and du	e to the cause(s)
To the	within To the	Me	29b. Signature and	title of certifier	4					e number		29d. Date	signed (Mon	th, Day, Year)
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		•	State of Maryland / Dep	eartment of Health and Mertificate of Death	Mental Hygie Reg.	ZUUb	40382
	Physici /Medio		1. Decedent's Name (First, Middle, Last) FREDERICK R. OLTMANNS		2. Date of Death Month December	Day 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) St. Joseph's Medical Center	4b. City, Town, or Location of Death Towson		4c. County of Death Baltim	ore
	Funeral Director		5. Social Security Number 212-34-4064 Sex X M 2 F 7. Age (In yrs. last birthda) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Ye July 1, 193	9 <i>8(</i>) (20)	pplace (State or Foreign untry) cyland
	Aaryland •how	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or town of the MD Baltimore Par	ocation kville			10d. Inside City Limits 1 ☐ Yes 24 No
	with the N Na or 28e-1	Direct	10e. Street and Number 8807 Richmond Avenue	10f. Zip Code 21234	10g.	Citizen of What Cou USA	intry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or items 23e or 28e-f ehow entry injury or other treumatic event, the Marifield Examinist rotal be notified at anote.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	id within 72 ho giene. er then "natur i. Ine Medical.	ompleted	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) Cad Operator	ana	RK & K	ndustry
land	uld be filed vental Hygierked other file event, Li	To Be (17 Father's Name (First, Middle, Last) Frederick A. Oltmanns		e (First, Middle, Mai abeth Lai		
	nd 2 shou alth and A 27 is ma		19a. Informant's Name/Relationship (Type, Print) Mary Oltmanns-spouse 880	ling Address (Street and Number or Run 07 Richmond Aver	al Route Number, Cr nue-Park	ity or Town, State, Zi ville, Ma	ryland
Baltimore,	Pages 1 a nent of Hei ent: If Item ury or othe		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition EVANS. Classes of Disposition Tapel and	osition (Name of MINERAL Place) Cremation-BelAir	A A	c. Location - City or T Drest Hi	own, State
Balt	permit. Departi Importi eny inj			22. Name and Address of Facility EVANS FUNERAL CHAPI AND CREMATION SERV			oad 21234 yland
	Physician /Medical	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):	cular disease			
8760,	ficate be executed physicien and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
.O. Box 68	The law requires that the death certifica sie has been signed by the ettending ph page 2 should be detached for use as th	by Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
٥.	v requires that been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute lo	
al Records,		Completed			24a. Was an autopsy performed	prior to co	opsy findings available omptetion of cause of 2 No
<u>₩</u>	ysician: Th is certificete director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatie	Othor	h (Check only one) me 5 Residence	e 6 ⊡Other (Spec	4.1
Division of Vital	ding Ph h. After th funeral	ation: T	27. Manner of Death 1	of 28c, Injury at	28d. Describe how i		19)
Divis	tal or Attants setter deatlal Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deal check only and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the causi red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
(F)		25	29b. Signature and interpresenting COMER NU	29c. License number	29d.	Date signed (Month)	Day, Year)
9	15		30. Name and address of person who completed cause of d. ath (Item 23a) (Type	Print) le Rd #20	2 Ton	ison M	D2128
	Sta Registr		31. Date filed (Month, Day, Yeal) 32. Registrar's Signature DEC 1 9 2006	Corte			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Casimir C. Piotrowski December 16, 2006 6:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 215-09-8230 86 Jan. Maryland Director 15,1920 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or 4206 Soth Avenue 21236 S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and I fitem 27 is marked other than "natural", or the ury or other traumatic event, the Medical Examines ury or other traumatic event, the Medical Examines 1 X Yes 2 No 42 -If Yes, Give 1942 -Year or Dates: 1945 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: Be Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Self Employed <u>Home Improvement</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Piotrowski Josephine Rapert ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troonce. 4206 Soth Avenue, Perry Hall, Maryland 21236 Bernice Piotrowski (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 12/20/2006 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21 Signature of Fure Listonice Liona approximaly 9705 Belair Road, Baltimore, Maryland 21236 23 a. P. ft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nodiate Cause (Final Physician debil disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying dause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide

The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760 the nse for s been signe should be c page 2 s Hospital or Attending Physician:

death with the Maryland

Baltimore, Maryland 21215-0036

funeral director by filled in

within 24 hours after death. To the Funeral Director: completely

State Registra

29a. Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

M

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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D0051926

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) haves St PPE 203 Bathman MD 21204

2006

Gordu ans 6565 W. Year)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 200 /Medical institution, give street and nu Location of Death 4c. County of Death Examiner Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√2 F 414-24-8685 80 Director 27, 1926 Nov. Tennessee Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiena.

Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 635 Wyeth Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ George Heath Martha Franklin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i James C. Heath / Son 301 Summerfield Ct. Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1

Burial 2 □ Cremation 3 □ Removal from State 12/19/2006 Brooklyn Park, Md. Cedar Hill Cemetery 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on e Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical for use as attending IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Other significant conditions contributing to death/out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 1□ Yes 2 1No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | 1 | Yes 1 poatient 2 ☐ ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident 24 hours after death Funeral Director: Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certife 29c. License number 29d. Date signed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMIND TTEM 5, per FH, C862, 12/19/06, WS
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 28 M Month Year **Physician** 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and 4b. City, Fown, or Lecation of Death Examiner Docours) r*e* 5. Social Security 9520 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, O 7 20 Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) If Under 1 **Funeral** Year) Days Min Months Hours 1□ M 2\□ F 245-54-95201 70 Yrs NC 36 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County Item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore MD NA Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 U.S.A. 1217 West Fayette Street Funeral 12. Was Deceden! Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Mamied 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. Specify: Black ģ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
9th grade Cotlege (1-4or 5+) Silver Bakery Designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bertha Leggett ٥ Douglass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Heelth and Importent; If Item 27 te in eny injury or other treum once. Annie McCallum-Daughter 2324 Larkin Ave, Savania, GΑ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 12/15/06 Baltimore, 4 Donation 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, 21. Signature of Funeral Service, Licenspe 23a. Part . Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spoke, or heart failure. List only one cause or each line. 21215 Approximate Interval Between Onset and Death nmediate Cause (Finat isease or condition isulting in death) **Physician** /Medical Que to (or as a consequence of): Examiner -ANDRONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine law requires that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit Due to (or as a consequence of) that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ M6 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy 2 No 1□ Yes 2 No To the Hospital or Attending Physiclen: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 (patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 2 ER/Outpatient 3□ DOA ဥ 1 TYes this 28a. Date of Injury (Month, Day Yeer) within 24 hours effer death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Dey, Year) 29c. License number title of certifie 29b. Signatu/a (Item 23a) (Type, Print) 30. Name and address of-DEC 1 9 31. Date filed (Month, Year) Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month 12 18 Day 2006 7:50a. M Mae Peters /Medical 4c. County of Death 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 05 27 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M **X**□F SC 71 Director 217-34-3938 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No NA Baltimore Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 North Eutaw Place Apt 119 21217 U.S.A. Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nurse 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Davis James H. Dessesaure ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Essex Road, Baltimore, Md 21207 Vera Lee-Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 12/21/06 Owings Mills, 4 □ Doration 5 □ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility arch F/H West any in 4300 Wabash Ave, Baltimore, 21215 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Make DAYS Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) the is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has Yes 1 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4□ Nursing Home 5□ Residence 6 Mother (Specify) ^oL this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? after death. Director: After Certification: (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles of Borners up 21724 Brass 2 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	larylan		artment rtificate			and M	ental Hy	giene Rag. No.	11116	40387
	sicia		1. Decedent's Name (First, Middle	IN PRI	FIG	SEL	_				2. Date of De	ath Way	- 200k	5° 30 A _M
	ledic amine		4a. Facility Name (If not institution, give street and number) Genesis Loch Raven				4b. City, Town, or Location of Death Baltimore					4c. County of Death Baltimore		
Fune Direc			5. Social Security Number 213–28–2910	6. Sex 1 □ M 2 🕶 F		la <i>st birthday)</i> 5 Yrs.	If Under 1 Months	Days	If Under: Hours	Min	8. Date of Bir (Month, Da April	th Year) 2, 1	9. Bi 931 Ba	rthplace (State or Foreign ountry) Ltimore, MD
aryland		ò	Usuet Residence of Decedent 10a. State 10b. County MD Balt	imore		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Marylan	and and	Direct	10e. Street and Number 2608 Burridge				10f. Zip (4				zen of What C	
INIAL YIALING KIKI IN 2000 nd 2 should be filed within 72 hours after death with the Maryland slith and Mental Hygiene. 27 is marked other then "naturs!", or flems 23e or 28e-f show		by Funeral Director	11. Marital Status 1 Never Mamed 2 Marr 3 Widowed 4 Divorced	12. Was Decedent	No.				,	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.))-	JSA 14. Race - Am Black, Whi SpecifyWhi	te, etc.
I within 72 hou iene.		Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education		(Give life.	dent's Usual kind of work DO NOT use emaker	(done d e retired)	ition furing most	t of workin	ng		nd of Business	s/Industry
2 should be file and Mental Hy is marked other	MIC even	To Be C	17. Father's Name (First, Middle, John Caperna	Last)							(First, Middle Viglia		Sumame)	
and 2 sho salth and I n 27 is mu	The read		19a. Informant's Name/Relations Robert Preisel			1744	Westo	n Av	ve. B				Town, State, and 21	, ,
Pages 1 ment of He	ury or our		20a. Method of Disposition 1: Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (S		Par	lace of Dispo emetery, crer KWOOd	sition (Name natory or oth Cemet	e of her place cery	1		^{ate} /2006		cation - City or Ville,	Town, State Maryland
Robert Preisel- Son 20a. Method of Disposition 20b. Place connect 1 Disposition 20b. Place connect 4 Donetion 5 Other (Specify) 21. Signature of Juneral Service Licensee							22. Name and Address of Facility Evans Funer Services-Parkville 8800 Har 21234					eral arfor	Chapel d Rd.P	& Cremation arkville,MD
Physic /Medi			23d. Part. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause on each a	125	fati		911		0.	(U)10		ì	Approximate Interval Between Onset and Death
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anding Plant.									how injury	w injury occurred				
To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A	ed in by me	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
hs Hosp in 24 hou hs Fune	completely tilled in	edicai	29a. Certifier 1 Cartifyin (Check only one) 1 Madical	g Physician: To the best Examiner: On the basis of and manner s	of examinat	wledge, death tion and/or in	occurred a vestigation, i	t the tim- in my op	e, date and inion, deal	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
To T To 1	000	Σ	29b. Signature and title of certifie	Attendir	19 1	Thyse	29c.	License	2 Compet	36	72	29d. Date	signed (Mon.	th, Day, Year) 7 2006
11			30. Name and address of person	who completed cause of	d th (Item	2 ay(Type.	Print)	5+	4	20	2 Ba	Hi:	nore	72006 21204
Reg	Stat gistra		31. Date filed (Month, Day, Year)		rar's Signa	ture	and the same							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day NC Pounds December 11, 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Martin's Home Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ★ M 2 □ F Months Min 87 719-03-1781 June 26, 1919 Alabama Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4009 Dee Jay Drive 21042 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: white 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore Gas and College (1-4or 5+) Electrical Engineer Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Newman C. Pounds, Sr. Marybelle Wilhite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10370 Globe Drive EllicottCity MD 21042 James Pounds/ Son 20b. Place of Disposition (Name of Commentary of other place) Holy Redeemer Cemetery 12-16-2006 Bel Air, Maryland 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Funeral Service 4328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRONIC FAILURE-STAGE 4 disease or condition resulting in death) Year Due to (or as a consequence of): SSEN TIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPOTHYROIDISM, COMPLETE 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown CHRONIC HEAR 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed VASCULAR PERIPHERAL 2 🔀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident

Physician /Medical Examiner I or Attending Physician: The law requires that the death certificate be executed attendeath.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burlar-transit in by the funeral director, page 2 should be detached for use as the burlar-transit. Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical ò Be Completed

Certification: To

Medical

3 ☐ Suicide

(Check only one)

29a. Certifier

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D18362

Ave Suite LL 10

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year) 12-11-2006

Balto. Md21229.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455, Wilkens

31. Date filed (Month, Day, Year)

DEC 19 2006



Registrar

112/

within 24 hours at

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Day + 2006 **Physician** 1:10 AM POKEMPNER ETHEL /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner KESWICK MULTI CARE CENTER BALTIMORE N/A If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth 10/14/1910 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔽 F 96 Yrs. MD 219-32-3956 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural" ~ " any injury or other traumatic avairable. 10c. City, Town or Location 10h County 10a State 10d. Inside City Limits 1 ▼ Yes 2 □ No Directo MD N/A BALTIMORE 10e. Sfreet and Number 10g. Citizen of What Country? 10f. Zip Code 21218 USA 4000 N. CHARLES STREET #1506 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coflege (1-4or 5+) Elementary/Secondary (0-12) OPERATION SPECIALIST STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **KRES** JACOB DORA LICHTENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 WILLOW AVENUE - TOWSON, MD 21204 JOSEPH K. POKEMPNER / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 12/18/ 2006 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Congrative heart failure **Physician** 16 hours /Medical Due to (or as a consequence of): Examiner Orferiokelerofic cardiovascular disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2 1No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Tyes 2 1 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number > or Tabelle Tac gregor or D D'13657 December 14,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. ISABELLE MARGREGOR, 700 W 404 STREET, BALTIMORE, MD &1211 31. Date fited (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 11:45 AM Charles William Rhoderick, JR 4a. Facility Name (If not institution, give street and number) December 12 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 14703 B Liberty Road Mt. Airy Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 X M 2 □ F 220-34-7378 Yrs. Director 31 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any njury or other traumatic event, the Madical Examiner must be notified at once. 10a State 10d. Inside City Limits 1 ☐ Yes 21 No MD Frederick Director Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14703 B Liberty Road 21771 US Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Dairymen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles William Rhoderick, SR Erma Virginia Wachter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Evelyn Rhoderick 14703 B Liberty Road, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Dec 18 2006 Woodsboro Rocky Hill Cemetery Maryland 4 Denation 5 Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory 21. Signature of Funeral Service Licensee anus call 1212 W. Old Liberty Road, Winfield, MD 21784 Enter the disease, or complications, or heart failure. List only one cau that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest is on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Physician minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant atten for u 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**X** No 2 200 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Morth, Day Year) Director: After the in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 11:35 AM 1 Natural hanged 112/2006 death. 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2003 BL: bearty Ro Mount Airy 07 home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mahner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number completed cause of death (ftem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32/Registrar's Signature State DEC 1 9 2006 Registrar

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Division of	To the Hospital or Attending Physician: within 24 hours after death a To the Funeral Director: After this certific completely filled in by the funeral director.	1-1	1-1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of fnjury (Month, Day Year)	ER/Outpatient 3☐ □ 28b. Time of Injury M	28c. Injury at Work?		me 5 Reside 28d. Describe ho	nce 6 □Other (Spe w injury occurred	ecify)				
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	10		30. Name and address of person who com	plet se o death (Item 20 (Senson	AVENUE	, Bal	timare	Man	yland.	21227					
4	Sta Registr	- 635	31. Date filed (Month Day Year) 9 201	32. Registrar's Signa	ture food				1						

State of Maryland / Department of Health and Mental Hygiene UU b 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:5ZAM December Kidge 4 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner Baltimare Medica If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 100 M 2□ F Days Months Hours 219-32-199 Yrs 70 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show way injury or other traumatic event, the Medical Examination must be notified at some. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21227 505 Carlsbad Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 SQ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3. Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Koppers 0 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Grace O'Brien ဥ Joseph Ridgely 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Catonsville, Maryland 21228 1704 Rockhaven Ave. Mrs. Ruth Vega / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery | 12/18/06 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Egrer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) static Colon Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-tran the attending physicien and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed 2100 1 Yes 2X No filled in by the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending | 24 hours after death. 5 Pending investigation Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green Street Baltime, MD 212DI or LARK im ber 1

Registrar

State

31. Date filed (Month, Day, Year)

DEC 1 9 2006

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** DECEMBER 10:00 M Helen Lena Sgambato 17 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington medical Center Arundel Glen Burnic Anne 8. Date of Birth (Month, Day, Ye June 29, If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F 577-34-0280 1927 Director Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits 28a-f show must be notified 1X Yes 2 No Director Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö or Items 23a 1212 Odenton Road, #214 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. the Medical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3XXWidowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Own Home item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvator Pusateri 2 Lena Branca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trauonce. Nancy Slavinski/Daughter 7029 Long View Road, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 12/21/2006 | Silver Spring, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Lice M00773 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician (do Choxic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any manufacture of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 Yes 2 10 No 9 Unknown Month 4☐ Pregnant at time of death 5 Other (specify) 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 24 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation Natural 2 Accident Iniury 1 ☐ Yes 2 ☐ No hours after death, Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24255 MN DECEMBER 17, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 :N Washing Medicul Baltimore 32. Rigistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

		1 - For State Registrar	State of Maryl	and / Depa		Health and I	Mental Hygi	-	5 40395	
Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last Edward 4a. Facility Name (If not institution, give Balt. VA Rehabilit	street and number)	Soper	4b. City, Town,	or Location of Death	2. Date of Death Month	Day Ye	6 07:20 AM	
Funeral Director		5. Social Security Number 6. Se		yrs. last birthday) Yrs.	If Under 1 Yea Months Days	r If Under 24 Hrs.	8. Date of Birth (Month, Day, July 3,		Birthplace (State or Foreig Country) aryland	
72 hours after death with the Maryland 72 hours after death with the Maryland natural; or Itema 23e or 28e-f ehow licel Examinet must be notified at	Director	10a. State 10b. County Maryland Baltimo. 10e. Street and Number		City, Town or Lo	white Marsh 10f. Zip Code			g. Citizen of What	10d. Inside City Limits 1 Yes 2 No	
r death with lema 23e or er mars be	Funeral DI	11725½ Hamilton 11. Marital Status	Place 12. Was Decedent Ever in U.S. Amped Forces?		21162 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			U.S.A.		
2 hours afte	ted by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15 Decedent's Edu	1 ☑ Yes 2 ☐ No If Yes, Give WW Year or Dates:	II	l ☐ Yes 2 💢 No	Specify:	1 1		White	
be filed within 72 hc tal Hygiene. d other than "nature ovent, the Medical	e Completed by	(Specify only highest grad Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		Sterer	e during most of wored) 18. Mother's Nan	ne (First, Middle, N		iture	
aryid should and Men is marke	To Be	Milburn W. Soper	rpe, Print)			Jennie at and Number or Ru	Marie Tral Route Number,	Bayline City or Town, Stat		
es 1 au of Hea fitem r othe		Mary Angela Soper 20a. Method of Disposition 1 X Burial 2 Commation 3 L 4 Donation 5 Other (Specify)	20 Removal from State	b. Place of Dispo cemetery, cren	sition (Name of natory or other pl	' 1	Date 2	0c. Location - City		
permit. Pag Department Important: I any injury o		27. Signatur of Floral Service Lo	7.	22	Name and Addr 1705 Bel	ess of Facility Sc. air Rd.,	himunek I Baltimore	Funeral H 2, MD 212	omes	
Physician /Medical Examiner		23a. Pfinf. Enter the disease, or combined to the process of combined the combined that the combined t	a. End St Due to (or as a con	ODE PO		one Bile		st,	Approximate Interval Between Onset and Death	
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w requires that the been signed by the should be detached.	þ	Part II. Other significant conditions con	ontributing to death but not resulting in the underlying cause given in Part I.					Did tobacco use contribute to the cause of death		
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ffe and	To B	examiner?	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	26. Place of 3 DOA Cther: 4 ursin 28c. Injury at Work? M 1 Yes 2 No		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred		pecify)	
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o the Hos ithin 24 hc o the Fun empletely f	Medical	29a. Certifier Check only one) 1 Sertifying Phy 2 Medical Exami	ner: On the best of my ner: On the basis of exame and manner stated.	niowiedge, death	estigation, in my	ime, date and place opinion, death occu	rred at the time, da	use(s) and manner te and place, and d d. Date signed (Mo	due to the cause(s)	
141	9	30. Nam and ddress of person who co	mpleted cause of death (. D . Item 23a) (Type, I	Print)	7804		12/15	-/2006	
Sta Registr	4	A. Mrowiec . 3 31. Date filed (Month, Day, Year)	900 Loch 32. Registrar's Si			Baltin	we MS	213	218	

DHMH 17 Rev 1/2001

DEC 1 9 2008 Move & 19

ORIGINAL

06-09633 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Garland Warren Shamer, III State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 17, 2006 WARREN SHAMER III 1713 hrs Medical Examiner (TARLAND 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Route 32 & Macbeth Way Sykesville 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreian Months Davs Director 39 Country) MM 1886 1 M 2 F 217 08 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show e notified at once. FINKSBURG 1 Yes 2 No CARROLL mo permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e Street and Number USA 21048 GAMBER ROOM Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Yes 1 Yes 2 No specify: Widowed Divorced If Yes. Give Year Specify: ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) FOGLE Elementary/Secondary (0-12) College (1-4 or 5+) 1 RUCK ORIVER 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) PATRICIA GARLAND W. SHAMER, NR COMMAD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD GARLAND W. SHAMER, NR FINKSBURG MO 21048 FATHER 3777 OLD GAMBER ROOD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12/22/2006 HAMPSTEAD, MD CARROLL CREMATION, INC Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee 6028 Sykewille Rd ELDERSBURG MO 21784 23a Fad Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Retween Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X AMENDED UNPENDED attending physician or use as the burial -#4b. perME certificate be Box 68760, IF FEMALE 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. ⋧ 1 Yes 2 V No 3 Probably 4 Unknown page 2 should be Completed peen s 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has l death? performed? 2 No certificate Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✓ Other: Scene this ို 1 V Yes 2 28a. Date of Injury (Month, Day Year) Dec 17, 2006 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred After 27 Manner of Death Certification: Driver auto motorcycle collision 1 Natural 1710 hrs 1 Yes 2 ✓ No 24 hours after death. Funeral Director: 5 Pending the 2 🗸 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
Route 32 & Macbeth Way, Westminster, MD determined (Specify) Major Road / Highway 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only To the one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title O.C.M.E December 18, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Examiner certificate has been signed by the ettending physician and $^{ imes}$ rector, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 of etter death.

Director: After After filled in by To the Hospital o within 24 hours eff To the Funerel DI completely filled in

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at

other then

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked other any Injury or other treumatic event.

Physician

/Medical

Examiner

Physician/Medical

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Completed

To Be

Certification:

Director

Funeral

Completed by

with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

			For State Registrer	State of Ma	aryland / Dep		lealth and M	lental Hyg	_	6 40398
			Decedent's Name (First, Middle, La	est)				2. Date of Deat	h	3. Time of Death
	Physici	an	Rhoda		ine	Stric	ckland	Month	Day Ye	1 1/10 14
K	_/Medic		4a. Facility Name (If not institution, give		Tire		Location of Death	DEC	4c. County of D	
4	Examir	er	ST AGNES		At		TIMORE	-	40. Oddiny of E	70411
					·	1	If Under 24 Hrs.			Birthplace (State or Foreign
	Funeral Director			Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. last birthday) 37 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 09	5 69 g.	Country) MD
			Usual Residence of Decedent							
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar roual be profilled at	Director	MD NA		Baltimo	re				Y Yes 2 No
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	deat ms	Jer	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		American Indian,
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Ö	er', c	þ	3 Widowed 4 Divorced	Year or Dates:		1 □ Yes χ □ No	Specify:		Specify:	Black
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P	e filed al Hygid I other vent, II	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Name	e (First, Middle, M	Maiden Sumame)	
<u> a</u>	should be f and Mental h marked of umatic eve	2	Walter L. Stri	ckland			Barbara	Bolli	ng	
Maryland	should be filed and Mental Hygi le marked other aumatic event, ii		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street	and Number or Run	al Route Number,	City or Town, Sta	te, Zip Code)
	1 and 2 Health a om 27 le		Barbara Strick	land-Moth	er 281	7 Arlene	e Cir.,	Baltim	ore, Md	21207
ē	of He of He fiterr		20a. Method of Disposition		20b. Place of Dispe				20c. Location - City	
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If Item 27 any Injury or other tr. <u>once.</u>		M Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Speci				1	19/06	Randall.	stown, Md
Ħ	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service Lice		2	2. Name and Addres	ss of Facility	ta (n. C-Cara P. C-O Ph.		DCO#117 11G
ä	permit. Departr Importe any Inje		Marine H	· Jomp	sm M	arch F/E 300 Waba	H West	Pal+i	moreo M	d 21215
			23a. Part1. Enter the disease, or con shock, or heart failure. List only			ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate
			shock, for heart failure. List only Immediate Cause (Final	one cause on each li	ne.		SEPSIS			Interval Between Onset and Death
Section 1	Physician /Medical		disease or condition resulting in death)	a			3 -1 2/3			UNKNOWN
	Examiner			Due to (or as	a consequence of):					
		6	Sequentially list conditions,	b. Due to (or ac	a consequence of):		-			
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	xecu and	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
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×	ding se as	/We	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of	dolivon
Box	atten for u	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
	the d	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	tuno or dodni					
P.0	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the bunat-transit	by Physician/Medi	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	undertvina cause av	en in Part I.	23e. Did tob	acco use contribut	te to the cause of death?
Division of Vital Records,	sign al be			J	•	, ,		1 □ Ye	s 2 No 3	Probably 4 DUNknown
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=	The cate	Completed						perform 1 Yes 2		Yes 25 No
/ita	cian ertifi ector	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	θ)	
=	hysi this c	ဥ	1 ☐ Yes 2 ☑ No		ent 2 ER/Outpatie		4 Nursing Ho		ence 6 Other (Specify)
n n	fter inerg	ë.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
Si	eath.	catl	2 ☐ Accident investigation				Yes 2□No			
Ξ	or Att	Certification:	3 Suicide 6 Could not l	286 Place of In	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (St. City or Town		r Rural Route Number,
	ital c rrs af ral D									
	tosp t hou une ely fil	ca		hysician: To the best miner: On the basis o						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one)	and manner st	ated.					
	5 Merican	-	29b. Signature and title of certifier	tamir (heema !	イル) 29c. Licens	anumber	7- 2	9a. Date signed (M	nonin, Day, Year)
			(3) H			D	000 > 0	27	DEC /	Month, Day, Year)
1	3 0		30. Name and address of person who	completed cause of c	leath (Item 23a) (Type	Print) AAM!	RA. C	CHEEM	A M.	· · · · · · · · · · · · · · · · · · ·
_			30. Name and address of person who 5124 STON 2 31. Date filed (Month, Day Year)	2140h C	IRCLE, O	WINGS	MILLS	IND	, 21/17	7
7	Sta		31. Date filed (Month, Day, Year)	9 2006 N	ar's Signature	Areals &				
液	Regist	rar	Sro T	a roan	SEASON SO	The same of the sa				

STRICKLAND, RHODA

			For State of Mary		rtment of F			iene g. No.200	6 40399				
*		•	Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death				
	Physici /Medic		Hazel M.		Smit	th	Month 12	07 2ď	06 01:35 M				
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of					
			2702 Woodview Road 5. Social Security Number 6. Sex 7. Age (h	n yrs. last birthday)	Baltir If Under 1 Year		8. Date of Birth	NA	. Birthplace (State or Foreign				
	Funeral Director	l	214-24-4801 1□M 2XF 8		Months Days	Hours Min.	(Month, Day,	Year) 24	Country) NC				
de.	pu ,		Usual Residence of Decedent	- Ch. Tauranda			12 01						
	laryla shov sd at	'n		oc.City,Town or Loc Baltimor					10d. Inside City Limits M We 2 □ No				
	the M 28a-f notifie	Director	10e. Street and Number	Darcinor	10f. Zip Code		10	Og. Citizen of Wha					
	3a or	iO le	2702 Woodview Road			21225		U.S.	•				
	death	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No-		American Indian, White, etc.				
36	s after ; or its amine	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No ☐ If Yes, Give		□Yes 2XNo		,	Specify:	Black				
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ed b	3℃ Widowed 4 Divorced Year or Dates: 15. Decedent's Education	16a. Deced	ent's Usual Occup	pation		16b. Kind of Busin					
215	hin 72 s. In "na Medic	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			during most of wor d)	king						
21	ed with	Completed	contege () is only	Nur	ses Ass				spital				
Maryland	be file	Be	17. Father's Name (First, Middle, Last) Unknown				ne (First, Middle, N	Maiden Surname)					
<u> </u>	hould d Mer narke natic	70	19a. Informant's Name/Relationship (Type. Print)	10b Mailin	a Address (Street	Martha and Number or Ru		City or Town Str	ata Zin Cada)				
Z	nd 2 sl Ith an 27 is r traur		Regina Smith-Daughter	1		iew Road		-					
	s 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition	20b. Place of Dispos cemetery, cren				20c. Location - Cit					
m 0	Page nent c int: If iry or		K Dunar 2 Cremation 3 Aemovarium State	Arbutus			L3/06 <i>i</i>	Arbutus	, Mđ				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	İ	21. Signature of Funeral Service Licensee) Ma	Name and Address F/I	ss of Eacility H West ash Ave	Baltin	nore, M	d 21215				
	*		23a. Part1. Enter the disease, or complications that caused the						Approximate				
	Physician		Immediate Cause (Final disease or condition	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Onset and Death									
	/Medical Examiner		resulting in death) Due to (or as a co	onsequence of).	er o								
Ro.		<u>-</u>	Sequentially list conditions, if any, leading to immediate	onsequence of):	0 m	N IUL							
	uted j ansit	Examiner	cause. Enter Underlying Cause (Disease or injury										
ó	exectan and rial-tra	Еха	that initiated events resulting in death) Last c. Due to (or as a co	onsequence of):									
8760,	icate be executed physician and s the burial-transit	dical	d										
9	death certific attending p	/Mec	IF FEMALE: 23c. If yes, outcome pf p	regnancy									
Вох	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	in the past 12 months?	☐Fetal death 3☐	Ectopic pregnancy Other (specify)	у		23d. Date o Month					
P.O.	t the d by the ached	hysi	1 ☐ Yes 2X No 4 ☐ Pregnant at tim 9 ☐ Unknown 9 ☐ Unknown		(4/4/4/2/								
	sician: The law requires that the de certificate has been signed by the erector, page 2 should be detached	Jy P	Part II. Other significant conditions contributing to death but n	ot resulting in the un	derlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?				
ord	equire	ted					1 □ Ye	es 200 No 3[☐ Probably 4 ☐ Unknown				
Records,	e law i	Completed					24a. Was ar autops	y prio	re autopsy findings available r to completion of cause of				
	i: The	Co					perform 1□ Yes 2	ned? dea 2 No 1 □	th? Yes 2□ No				
Z.	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	t 3□ DOA Oth	or.	th (Check only one		(0 - 1/1)				
0	g Phy er this	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injur Wor		ome 5 💢 Reside 28d. Describe ho		Specify)				
ior	ath. or: Aft	atio	2 Accident investigation	ear) Injury		Yes 2 □ No							
Division or Vital	or Attending ifter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (3	At home, farm, stre Specify)	eet, factory, office		28f. Location (Str City or Town		or Rural Route Number,				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifie 12 Certify)ng Physician: To the best of m	ny knowledge, death	occurred at the ti	me, date and place	, and due to the os	use(s) and mann	er as stated				
	the Hospital hin 24 hours a the Funeral npletely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner stated	amination and/or inv	vestigation, in my	opinion, death occu	rred at the time, da	ate and place, and	d due to the cause(s)				
	To the within 2 To the comple	Me	29b. Signature and title of certified	(29c. Licens	e number	29	9d. Date signed (A	Month, Day, Year)				
	-		DAM Kund BALL	MAN	P	00200	14	12/1	2/06				
	1)		30. Name and address of person who completed cause of death	(Item 23a) (Type, I	Print	700 WO	to and	& row	Wd.				
	Sta	te	31. Date filed (Month Par. Year) 2006 32 Begistrar's	Signatute	arei	,00 ,00	2000	,					
	Registr	ar	APATA FAM		30 TOB.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amen 10g, per FH,g869, 7/31/07 TT Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Stewar Month Vear **Physician** ember 13 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Jom Q NA Komwel Towson If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Yea, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**∑**M 2□F 69 6-10-1937 Director 215-90-3696 Jamacia Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh 1 XYes 2 No Baltimore Director Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 2738 Tivoly Ave. ral", or items 23a Examiner must b Jamaica Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-li Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Iem 27 is marked other thar Local 516 Construction 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Mitchell Stewart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Raltimore, Md. 21218 19a. Informant's Name/Relationship (Type. Print) 2738 Tivoly Avenue, Baltimore, Md. Olive Stewart Wife item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-20-06 Baltimore, Md. Parkwood Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East , Baltimore, Md. 21202 1101 E. North Ave. war O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl 24a. Was an 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 ☐ Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Ater this funeral of 27. Manyer of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No Director: / 2 Accident 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 29b. Signature and title of cer Name and ordress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar (Month, Day, Year)

Ďate til

32. Registrar's Signature

06-09513	Please Type or Print in Black Indeli		egible.			
UNK UNK		ent of Health and Mental Health and Mental Health	Reg. No. 2006 4040			
	Registrar 1. Decedent's Name (First, Middle,Last) RONALD NATHANIEL STEWART I	2. Date of De				
3500mm	4a Facility Name (if not institution, give street and number) Sinai Hospital	4b City, Town, or Location of Death Baltimore	4c. County of Death			
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birth	"	irth(MM/DD/YYYY) 9. Birthplace (State or			
Director	220-88-2365 1XM 2F 29	Yrs. Months Days Hours Min. 03/2	9/1977 Foreign ARYLAND			
v any	10a. State 10b. County 10c. City, Town		10d Inside City Limits			
faryland 18a-f show 1 at once. ector	MD BALTIMORE RAS 10e. Street and Number	PEBURG	1 Yes 2 XNo			
th the Maryland 23a or 28a-f sho notified at once.	23 BOYMANS COURT	21206	USA			
or items 23. Tunest be no	11. Marital Status 1 X Never Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 				
15-0036 Flied within 72 hours after death with the Maryland I Hygiene. Let other than "natural", or items 23a or 28a-f she Life Medical Examiner must be notified at once e Completed by Funeral Director	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify	Specify: BLACK			
hours after "natural", Examiner ted by	, o. 200020111 o 2000201101 (op. 111) 1119 1119 1119 1119 1119	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b Kind of Business/Industry			
5-0036 ed within 72 hour lygiene. to the Medicial Exau Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12TH	CONSTRUCTION	SELF-EMPLOYED			
15-0036 filed within 7 Hygiene. d other than the Medical	17. Father's Name (First, Middle, Last) RONALD N. STEWART	18 Mother's Name (First, Middle				
2121 could be fi d Mental d Mental is marked lic event.		JENNIFER H b. Mailing Address (Street and Number or Rural Route No.				
, MD 21215-0036 and 2 should be filed within 72 calth and Mental Hygiere. rem 27 is marked other than ' traumatic event, the Medical ' To Be Completed.		23 BOYMANS CT., RASPEB of Disposition (Name of cemetery, Date	URG MD 21206 20c. Location - City or Town, State			
Ore, ges lar t of Hee : If ite	1 Rurial 2 - Cremation 3 Removal from State cremate	ory or other place) O CREMATORY 12/21/06				
Baltimore, MD 21215-003 permit Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other the injury or other traumatic event, the Medinjury or other traumatic event.	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility HOWELL F	,			
	26a. Poor 1. Enter the disease, or complications that caused the death to no	1 4000 PIREKLA HEICHLS	AV, BALTIMORE, MD			
Physician /Medical	fajlure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wounds	of the field of dying, book as building of respiratory s	8etween Onset and Death			
Examiner	or condition resulting in death) Due to (or as a consequence of):					
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause					
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.					
se executed cian and irial - transit dical Ex	UNPENDED AMENDED					
68760, certificate be ending physicial seas the burial can // in and // in a	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregnancy	23d Date of delivery Month Day Year			
arth or us	past 12 months? 4 Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown	Other (Specify)				
P.O. Bc est that the dec	Part II. Other significant conditions contributing to death but not resulting	g in the distant judge date given in the	tobacco use contribute to the cause of death? 'es 2 V No 3 Probably 4 Unknown			
ds, P quires t en sign uld be c		24a Wa	is an 24b. Were autopsy findings available			
Division of Vital Records, Island requirement and artending Physician: The law requirement and Director. After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed			opsy prior to completion of cause of death? 1 Ves 2 No			
al Re ertifica ctor. pa	25. Was case referred to medical	26.Place of Death (Check only one)				
f Vita Physicia or this ce ral direc	examiner? 1 Ves 2 No 27. Manner of Death No Hospital. 1 Inpatient 2 ER/O 28a. Date of Injury 28b.		Residence 6 Other:			
	1 Natural 5 Pending FOUND: FOUND: FOUND: 13 2006	JND: 1 Yes 2 ✓ No Subject w	as shot			
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office building, etc. 28f. Location	(Street and Number or Rural Route Number, City , State) of West Belvedere Avenue, Baltimore, MD			
D tospital 4 hours 4 hours all fille	29a. Certifier	ath occurred at the time, date and place, and due to the ca				
To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.	investigation, in my opinion, death occurred at the time, da	te and place, and due to the cause(s)			
Ž Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.				
	Hamuat Juffley, MA 30. Name and address of person who completed cause of death (Item 23a)					
	Pamela E. Southall, MD Assistant Medical Examine					
State Registrar		Aparle"				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 12:39 orothe Smith Dec 2006 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F 88 SEP 1918 Director 577-18-8114A Rhode Island Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Yes 2□No **Funeral Director** VA Fairfax City Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9451 Lee Hwy Apt 616 22031 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward F. Ney ၉ <u>Margaret Shea</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3552 Lakeway Dr Ellicott City, MD 21042 Penny Ford-Bezdikian/Daughter Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc 12/17/06 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility Cremation Society of Maryland, Inc. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, larged the Course (T Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rement a /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft To the Funeral Di completely filled in Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

Greene

31. Date filed (Month, Day,

Street

32. Registrar's Signature

			1 - State Registrar	State of Ma	ryland / I	Departme <i>Certifica</i>			and Me		ene No. 0 (16	404	03
	W.	98	Decedent's Name (First, Middle, Last)					2	. Date of Death			3. Time of	Death
	Physicia		Albert	W.		Startt		Sr.	De	Month ecember	18. 20	Year 006	3:45	a ^M
g.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)				or Location o			4c. County			
			3558 Kump Station	Road			Tan	evtow	n		Ca	arro	11	
	Funeral		Social Security Number 6. Se	x 7. Age	(In yrs. last bi	Month	er 1 Year		24 Hrs. 8 Min.	Date of Birth (Month, Day, Yuly 26,	ear)	9. Birth	place (State o	r Foreign
н	Director		219-22-1317	XM 2□F 7	7	Yrs.	54,0	1.00.0	Jı	uly 26,	1929		MD	
	pur *	}	Usual Residence of Decedent 10a, State 10b. County		10c. City, Tow	n or Location]	10d. Inside Ci	tv Limits
	fanyli	ъ	MD Carrol	_	**	8 Kump	Stat	ion R	oad			į	1 ☐ Yes	•
	28a-	Director	10e. Street and Number	<u></u>			Zip Code			100	. Citizen of W	/hat Cor	intry?	
	with Mary		3558 Kump Stat	ion Road		1	•	1787				S.A	-	
	ne 23	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dec			gin? (Specif	ty Yes or No- can, etc.)			ican Indian,	
(0	r Iter	핕	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					, Puerto Rio	can, etc.)	Blac	k, White		
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or lteme 23e or 28e-f ehow the Madical Examiran the notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes	2 √. No	Specify:			Specify	:	White	
2-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ication	16a	Decedent's Us	sual Occup	oation	of working	16	b. Kind of Bu	siness/li	ndustry	
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e,	permit. Pages 1 and 2 Department of Health Importent: If Item 27 I eny Injury or other tra		20a. Method of Disposition	WIIC	20b. Place o	of Disposition (A	lame of		Date		c. Location -			
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0	0 0 2	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death	5 🗌 Other (specify) _						,	
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	Phys or this oral dii	. To	27. Manner of Death	28a. Date of Injury (Month, Day		Time of	28c. Injur			d. Describe how			ny)	
lon	th. : After	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury M		rk? ∣Yes 2∐1	No					
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Exam	vsician: To the best of iner: On the basis of	my knowledg	e, death occurre	ed at the til	me, date and	d place, and	d due to the caus	se(s) and mai	nner as	stated.	
	the Hin 24 the Figure Poleste	edicai	one)	and manner stat	ed.				in occurred	at the lime, date	and place, a	na aue i	to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	e N	1. D.			se number	-)		. Date signed			
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	10		30. Name and address of person who o			(Type, Print)	·70-	1	Poni-	- 0-	WE	SIM	NSTAR	
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			_ FOI	epartment of Health and M Certificate of Death	lental Hygien Reg. N	2000 40404
Ī	Physici	_	1. Decedent's Name (First, Middle, Last) Thomas J. Sweeney, Sr.		2. Date of Death Month DECEMB	3. Time of Death Ay Year ER 16, 2006 9:13 ^M F
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cent	4b. City, Town, or Location of Death		c. County of Death Baltimore
A A	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birtho	Months Dave Houre Min	8. Date of Birth (Month, Day Yea OCT 26,	9. Birthplace (State or Foreign 1930 Pennsylvania
	e Maryland sa-f show tified at	Director	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1
	th with th 23a or 28 ist be no	al Dire	10e. Street and Number 9 Maybrook Court	10f. Zip Code 21057	10g. C	Citizen of What Country? USA
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 1 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	d within 72 ho giene. r than "natu the Medical	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) Tine Pilot	ing	Kind of Business/Industry
land	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Thomas A. Sweeney	18. Mother's Name Eleanor	e (First, Middle, Maide Miller	en Surname)
, Mary	and 2 shoualth and M		Mrs. Juanita Sweeney/ Wife	lailing Address (Street and Number or Run Maybrook Court Gle		
Baltimore, Maryland	Pages 1 ament of He ant: If item		4 Donation 5 Other (Specify)	ciematory or other place) n Cemetery 12-20)-06 Hy	Location - City or Town, State ydes, Md.
Balt	permit. Departimporti		21. Signature of Funeral Service Licensee	22. Nampane kddm Swysolly Fur 1050 York Rd. 1	neral Home Towson, Md	Inc. 21204
4	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DISSECTING Due to (or as a consequence of)	THORACTIC ADRTI		Approximate Interval Between Onset and Death
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or Vital Records,	The law requir ate has been si bage 2 should l	Completed	GEREBROVASCOLAR ACCIDENT		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
/ital	cian: 'ertifica	Be	25. Was case referred to medical examiner?		1 Yes 2 SH h (Check only one)	70 10 10 20 10 10 10 10 10 10 10 10 10 10 10 10 10
or	Physi er this c eral dire	To	1	ne of 28c. Injury at	me 5 Residence	6 ☐Other (Specify) jury occurred
sion	Attending Physician: r death. ector: After this certification of the funeral director, I	ation	1 Natural 5 Pending (Month, Day Year) Inju 2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	tal or Att s after d al Direct ed in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/of and manner stated.	leath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number DØØ53464	29d. E	Date signed (Month, Day, Year)
•	10+1		30. Name and address of person who completed cause of death (Item 23a) (Ty		MATTER AND AND AND AND AND AND AND AND AND AND	T
İ	Sta Regist		31. Date filed (Month, Day, Year) DFC 1 9 2006	ER DRIVE TOWSON,	THE YEAR	U = 1 = 104
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DECEMBER

SCHMIDT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #27, perMD, g864, 2/12/07 TT Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 17 2006 >005 borah /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** LOMNS Hospita 10 If Under 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min Hours 1 ☐ M 2 🙀 F 220-48-6877 1963 Director March 21, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If Item 273a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Me Item Examiner must be notified at 1 Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1027 Barrymore Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick A. Brown Mary Lou Louthan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Soos/husband 1027 Barrymore Drive, Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/20/2006 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. Gardens Timonium, MD. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signative of unera Service License 5. Coster 1050 York Road, Towson, Mary 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, Maryland 21204 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** uh mo Many Hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed as the burial-transi attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 □Ectopic pregnancy Month Day 5 Other (specify) signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an s certificate has t lirector, page 2 s autopsy performed? 2 No 1 Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2∏ No 2 ER/Outpatient 3 DOA 1 Inpatient P 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Injury (Month, Day Year) 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES - 000 Garonzik-Wang, Medical Duton 17,2006 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Ecqueline Garonzik-Wang, THE JOHNS HOPKINS HOSPITAL, 600 North Walfe Street D Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Registrar

5

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

027838

518 CAMP MILAMIN RUAD, LINTHICUM, MO 2109C

DIBCHAIL 14, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State	of Marylar		ertment of F				200	6	40408
			Registrar 1. Decedent's Name (First, M.	iddle Lasti		001	incate of	Deain		Date of Death	3.11022	-	3. Time of Death
	Physici		Joseph Edwar							Month e cemb e:	Day '	_{Year} 006	4:00 P ^M
	/Medi Examir		4a. Facility Name (If not institu				4b. City, Town, o	r Location of			4c. County of		4.00 1
			Upper Chesape	ake Medica	1 Center	r	Bel Ai	r			Harfo	rd	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under		Date of Birth	Year)	9. Birthpli	ace (State or Foreign
	Director		218-18-7495	1 ⊠ M 2□F	82	Yrs.		11000	Ai	Month, Day, ug. 12	, 1924		ýland
	and w		Usual Residence of Decedent 10a. State 10b. Cou		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Limits
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	r 28a	rec	10e. Street and Number	11014		OTESC	10f. Zip Code			10	g. Citizen of Wi	nat Count	ry?
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	death	ner	11. Marital Status	12. Was De	ecedent Ever in U Forces?		Was Decedent of H f Yes, specify Cuba	lispanic Ori	gin? (Specify	Yes or No-	14. Race	- America White, e	
0 %	or It	Y Fu	1 Never Married 28 N	Married 1X1Yes	s 2 No		Yes 2⊠ No			, 5.6./	Specify:		
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12/14/06	and and marth		Barbara B. St	eedman/Wi	fe	106-	C Gwen D	rive,	Forest				
7	P Ses 1		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremati	on 3 🗆 Removal from	m State	cemetery, cren	sition (Name of natory or other place	.	Date		0c. Location - C	•	
7	Page tment o tant: If		4 ☐ Donation 5 ☐ Othe	r (Specify)	H		Service	-	12–17-		owson, 1	Mary.	land
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Joseph	2 st	ple	altech	Deles	riun	1.de	Mau	00		24a. Was an autopsy	24b We	ere autop	sy findings available pletion of cause of
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teedman 1	s affe	Certification:	4 Homicide del	bui	lding, etc. (Speci	(y)			1	City or Town,	State)		
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	he M 28a-f otifie	Director	Maryland Baltimore		Essex					
	a or	۵	2634 Holly Beach Road		10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
	eath Is 23 must	era	11. Marital Status 12. Was Decedent Ever i	n II S 13	Was Decedent of Hi	21221	pacity Vas or No.	Unite	d Sta e - America	
36	of 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ※XX No		o Rican, etc.)	Blac	k, White, e	
9	2 hou latura ical E	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/Ind	ustry
215	hin 7 e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	- (Give	kind of work done of DO NOT use retired,	funng most of wor)	king			
21	filed within Hygiene. other than '	9	7 Years	H	omemaker			Own	Home	
Maryland 21215-0036	2 should be filed withing and Mental Hygiene. is marked other than aumatic event, the M	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle,		ie)	
Ya	should be and Mental s marked o	ို	Henry Laubach				ra Frank			
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Type. Print) Eugene C. Salvo, Jr. (Son)		ng Address (Street a					,
	1 an Heal			b. Place of Dispo	Rogers A	ve. Ell	icott Ci	ty, Mar 20c.Location -		
JO.	S 50 E		MXBurial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other place	í i			•	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	olly Hil	1 Mem. Gd 2. Name and Addres	ns. 12/	18/2006	Middle	Rive:	r, Maryland
Ba	Dep Imp		Macly Car		Duda-Ruck 7922 Wise	Funeral Ave. I				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that called the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (Assistance)	seque a of	ner the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Anset and Deth
Pa		ē	Sequentially list conditions, if any, leading to immediate	sequence of):	VIII	CCGN			-) years
	ansit	Examiner	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							,
o,	icate be executed physician and street transit		that initiated events resulting in death) Last C. Due to (or as a con:	sequence of):						
8760,	ate be nysicia he bu	dical	d							
9	entifica ing ph e as th	Med	IF FEMALE:							
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant In the past 12 moorts? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mor	e of deliver nth [y Day Year
rds, P.	w requires that the been signed by the should be detache	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	en in Part I.				cause of death?
or Vital Records,	The law ate has b page 2 sł	Completed				·	24a. Was a autops perfort 1∐ Yes	med? p	rior to com leath?	sy findings available pletion of cause of
<u>K</u>	Physician; This certificatral director, p	Be	25. Was case referred to medical examiner?		Otho		th (Check only on			
0	Phys this al dir	P	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 27. Man of Death 28a. Date of Injury	2 ER/Outpatier 28b. Time of		4 ⊡ Nursing H		ence 6 Othe)
o	ding .r. After funer	ion	1 Natural 5 □ Pending (Month, Day Year		Work	? ∕es 2 □ No	28d. Describe ho	ow injury occurre	ea	
Division	or Attending after death. Director; Aftel in by the fune	fica	3 Suicide 6 Could not be 28e. Place of injury - A	t home, farm, str			28f. Location (St	treet and Numbe	er or Rural	Route Number.
5	al or / after I Dire d in b	Certification:	4 Homicide determined building, etc. (Spe	∍cify)			City or Town	n, State)		
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director;	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death	h occurred at the tim evestigation, in my op	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ma late and place, a	nner as sta and due to	ited. the cause(s)
	To the To the Company	Me	29b. Signature and title of certifier		29c. License	number	11 2	9d. Date signed	(Month, D	lay, Year)
	;		P (4// 1//.		\perp \perp \perp \perp	44 +9)	_1//	1151	16
	6		30. Name and address of person to completed cause of death (I		·	-		t		
	۲		Ali Sanai, M.D. 6730 Holabiro 31. Date filed (Month, Day, Year) 32. Registrar's Si		Dundalk,	Maryland	21222			
	Sta Registr		DEC 1 9 2006	K A	Coals D					

DHMH 17 Rev 1/2001

ORIGINAL

06-09481 Joseph Simms

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician*il* Month Day December 12, 1450 hrs Medical Examiner Joseph Clarence Simms 2006 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Sinai Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months Director 41 07/01/1965 Country) MD 1X M 2 unknown Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b County MD 1 Y Yes 2 No Baltimore 28a-f show Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number nust be notified at 23a or 15 North Gilmor Street 21223 Funeral Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? Never Married 2 Married 2 X No Yes Specify African American f Yes, Give Year Yes 2X No specify: Widowed Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry ges 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.

If item 27 is marked other than "naturs ther traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 unknown unknown 12th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Lawrence Clayton Simms Jane Diane Diggs Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Lawrence Clayton Simms / Father 15 North Gilmor Street; Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition

1 Burial 2 Crer Date crematory or other place) 2 Cremation 3 Removal from State portant: | 12/18/2006 King Memorial Park Randallstown, Maryland ent Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland art I. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a Gunshot Wound of Pelvis Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery attending phys or use as the bi IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed b ۵ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? ✓ Yes 2 1 🗸 Yes After this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ 2 PR/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient 1 🗸 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Dec 12, 2006 Subject shot 1402 hrs Natural Yes 2 V No 5 Pending Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 Suicide or Town State 3900 Blk Bonner Road, Baltimore, MD determined (Specify) Local Street Funeral 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 / Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I one) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E December 13, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31 Date filed (Month State 2006 Registrar

DHMH 17 Rev 1/2001 **OCMF 2006**

	State Registrar		Cert	tificate of	Death	Reg.	No. 200	5 404	
	Decedent's Name (First, Middle, Last) NOAH	D.		SUGAI	RMAN	2. Date of Death Month	Day Year 15 . 200		
	4a. Facility Name (If not institution, give	street and number)			or Location of Deat	100	4c. County of De		
	SINAL HOSPITAL	01 011	ORE	Bolti we	0-1	5.		N/A	
	5. Social Security Number 6. Security Number 218-88-9650	7. Age (In yrs.	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yell)	9. Bi	rthplace (State or Foreign Country) MD	
	MD 10b. County BA	LTIMORE 10c. Cit	y, Town or Loca BALTI					10d. Inside City Limits 1 ☐ Yes 2 No	
	10e. Street and Number			10f. Zip Code	01000	10g.	Citizen of What C		
+	13 HAWTHORNE AV	ENUL 12. Was Decedent Ever in U.	S 13 W	as Decedent of I	21208	pecify Ves or No-	14. Race - Am	USA perican Indian	
	1 Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes, specify Cub ☐ Yes 2【X No	Hispanic Origin? (Span, Mexican, Puer Specify:	o Rican, etc.)	Black, Wh		
1	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give k	ent's Usual Occu	during most of wor	rking 16l	o. Kind of Busines	s/Industry	
-	Elementary/Secondary (0-12) NONE 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	NONE	O NOT use retire		NO)NE		
	ALLEN		UGARMAN		SONY	Α		SHUMAN	
	19a. Informant's Name/Relationship (Ty	MOTHER		,		Iral Route Number, C BALTIMORE		•	
1	20a. Method of Disposition	20b. F	Place of Dispos		i		c. Location - City of		
	1 Ă Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (<i>Specify</i>)	removal from State			TERY 12/	17/2006	ROSEDAL	E, MD	
ľ	21. Signature of Funeral Service Licens	ee				L LEVINSON			
+	One Parti Franche disease or commi	isostians that assessed the death				ROAD - PIK		MD 21208 Approximate	
	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Pneuwon Due to (or as a conseq	10					Interval Between Onset and Death	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseq	s a consequence of):						
	that initiated events resulting in death) Last								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 □I	Ectopic pregnand Other (specify) _	ey		23d. Date of d	elivery Day Year	
	Part II. Other significant conditions co Method Retards	tion, Chron	1050m	el ah	ven in Part I. NO 6 M OL		: /	to the cause of death? Probably 4 □Unknown	
	ties, Hermaphic	polite, Pert	hes o	lisease		24a. Was an autopsy performe 1 Yes 2 €	24b. Were a prior to death?	autopsy findings available completion of cause of	
-	25. Was case referred to medical examiner?			1		ath (Check only one)			
	1 ☐ Yes 2 ☐ No		ER/Outpatient			lome 5 Residence		ecify)	
	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Inju Wa M 1 [ıryat ırk?]Yes 2∐No	28d. Describe how	injury occurred		
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, stre			28f. Location (Stree City or Town, S	et and Number or I State)	Rural Route Number,	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and due to the cause(s) and due to the cau									
29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon									
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State Registrar

DHMH 17 Rev 1/2001

Laren

		1 - For State Registrar	State	of Maryla	_	artment of H		d Mental Hy	giene	06	40412
Physic	ian	1. Decedent's Name (First, Midd						2. Date of De Month	Day	Year	3. Time of Death
/Med	ical	Helen Grossma 4a. Facility Name (If not institution)		umbarl		4b. City, Town, or	Logation of D		er 16,	2006 by of Death	2:30 a M
Exami	nér	818 Comer Squ		umbery			Air	adiri		Harfo	rd
Funera Director		5. Social Security Number 217-24-3480	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bi (Month, D Nov. 2	rth ay, Year) 2, 1928	9. Birthp Cour Mary	place (State or Foreign htry) Land
pu *		Usual Residence of Decedent 10a. State 10b. Count	M.	100.0	ity. Town or Lo	antion					
Maryla f ehov	5		arford	100.0	ity, fown or Lo	Bel Ai	r			1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
n the l	Irect	10e. Street and Number				10f. Zip Code	· L		10g. Citizen of	What Cour	
ath wit	raiD	818 Comer Squ	are				1014		U.S	.A.	
parition of a line of yearing a Landon operation. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examina must be notified at another.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	rried Amed F	2□No live X		Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2☐ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No Jerto Rican, etc.)	o- 14. Ra Bla Speci	ce - Americack, White,	
2 hou	ted	X 15. Decede	nt's Education		16a. Dece	lent's Usual Occupa	ation		16b. Kind of 8	Business/Inc	dustry
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id be f ental h ked of	To Be	Joseph Grossma						ia Spangl		тө)	
al yid and Men s marke	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	g Address (Street a	and Number or	Rural Route Numb	er, City or Town	, State, Zip	Code)
and 2 and 2 lealth a m 27 is		Patricia T. Ru	ıssell/dau		818	Comer Squ	are, Be	el Air, M			
Pages 1 nent of Hi ant: If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation				sition (Name of natory or other place		Date	20c. Location	,	
nit. Pa artmer artmer brtant injury		'4 □Donation 5 □Other (Gar		Forest VA Name and Addres		2/20/06	0wings	Mills	s, Md.
permit. Departn Imports any inju		Xam Rim	ninh.		So	chimunek :	Funeral	Home of			
DATE OF THE PARTY OF		23 Part . Enter the disease, of shock, or heart failure. Lis	or com in ations that it only one cause on	caused the dea	ath. Do not ent	or the mode of dying	g, such as card	lead, Bel diac or respiratory a	Air, Mo	1. 210	Approximate Interval Between
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/Medical Examiner		resulting in death)	Due to	o (or as a conse	equence of):		/				
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icate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to	o (or as a conse	quence of):						
physic physic the b	dicai		d								
that the death certificated by the attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr					23d. Da	ate of delive	erv
death	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No		birth 2 ☐ Fet gnant at time of		Ectopic pregnancy Other (specify)			М	onth	Day Year
at the	Phys	9 Unknown						00 011			
sign a be	ed by	Part II. Other significant condit	ions contributing to	death but not re	suiting in the ur	iderlying cause give	ın ın Part I.				ne cause of death? abiy 4 24 mknown
law requ	Completed	1						24a. Was	an 24b.	Were autop	psy findings available mpletion of cause of
yeician: The law is certificate has b								1 Yes	2 No	death? 1 🗌 Yes	
yeiciar yeiciar is certif directo	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3□ DOA Othe		Death (Check only of Home 5 AResi		(0	=
ding Phy h. After this funeral d	}	27. Manner of Death	28a. Date		28b. Time of Injury	28c. Injury Work	at Nursing		how injury occur		"
tandin death. tor: Aft	atio	- C , 100 GOIT	igation	inii, Day 16ai)	Injury		r ∕es 2 □ No				
or Attancatter death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	e of Injury - At h ding, etc. (Spec	nome, farm, stre ify)	et, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	l Route Number,
To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certify	ng Physicien: To th	e best of my kn	lowledge, death	occurred at the tim	e, date and nla	ace, and due to the	cause(s) and m	anner as et	ated
n 24 h	edicai	(Check only 2 Medice one)	Exeminer: On the	basis of examin nner stated.	ation and/or inv	estigation, in my op	inion, death or	curred at the time,	date and place,	and due to	the cause(s)
To the To the Comp	M	29b. Signature and title of certifi	er /			29c. License			29d. Date signe		
		Marcy 1	Pomlula	MD.		100	21022		12-1	8.02	
10		30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type, I	Print)	771 118	21275			
St	ate	31. Date filed (Month) as Year	9 2006 32	Registrar's Sign	natur	1 No DAG	ou m',	dell			
Regist		DL O I	0 2000	ELLES.	10. Ja						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMOND TEM#5 Decret G864.2/2/07 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Madalyn C. Thomas 11:15 P M December 16, 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 116 Hapsburg Court Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Yrs. 84 April 25.1922 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Parkville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8724 Richmond Avenue 21234 u. s. Α. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 □ Divorced Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security Administration Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Pinkas Marie Hoernlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Greenwald (Friend) 8835 Green Needle Dr., Baltimore, Maryland 21236
Date 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State * 4 Donation 5 Donation 5 Other (Specify) Dulaney Val. Mem. Gdns. 12/20/2006 Timonium. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes pereo 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Melanoma Malignant Due to (or as a onsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 25 No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Friend's Other: 4 Nursing Home 5 Residence 6 X Other (Specify Home) Hospital: 1 Tes 2 Ho 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -physician 4.4. Schunders

D39758

Box 68760. Records, P.O. Division of Vital

attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ed by the a After s after dea... within 24 hours a To the Funeral I

Physician

/Medical

Director

Completed by Funeral

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Examiner

by Physiclan/Medical

Completed

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Certification:

Examiner

Funeral

Director

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in than "natural", or items 23a or 28e-f show the Modical Extention must be putified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Mudical Extended Proce.

Pnysician /Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

2006



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#18 per FH, G862, 12/19/06 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year DECEMBER Day **Physician** ERTHA THOMAS 4:121 17 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NO PATINEST RANDALLSTOWN HOJPIT4L BALTIMORE 5, Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 102 Yrs. Director 1904 Va 228-30-2052 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r then "natural", or items 23s or 28s-f show the Modical Examiner must be notified at Director 1 Yes 2 No MD Pikesville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Smoke Tree Road 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 10 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: þ X Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 6th grade College (1-4or 5+) permit. Pages I and 2 should be filled will Department of Health and Mental Higgient important: if item 27 is marked other the any injury or other traumatic event. Item once. Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha Wilks Willie Wilks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Johnson-Daughter 804 Smoke Tree Road, Pikesville, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Community 12/22/06 Greensville Co, 21. Signature of Fu and ervice Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCIEROTIL CARDIOVASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): ettending physicien Box 68760 death certificate be Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 🗆 Yes 2 🕡 No 23d. Date of delivery 3 Ectopic pregnancy ö Year Month Day 4 Pregnant at time of deeth 5 Other (specify) the Division of Vital Records, P.O. detached 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Whitnown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 🗌 Yes 2₽No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certition completely tilled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 FR/Outpatient ပ 3 DOA 27. Manuer of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who DECEMBER 17 MIS 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) RAMDAUSTOWN MARYLAND 5401 ROTHKIN DUD COULT ROKO 21133 MIGHAEL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DEC 1 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 1:05 PM AMES TAYLOR DECEMBER 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner FOREST HAVEN NURSING HOME BALTIMORE ATONS VILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Months 0970971906 1 XM 2 ☐ F 100 MARYLAND 213-20-6438 Director Usual Residence of Decedent 10c. City, Town or Location ir then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits MD BALTIMORE CATONSVILLE 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 EDMONDSON AVENUE death Funeral 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ₹ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BALTIMORE CITY permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event. It we apprice. Elementary/Secondary (0-12) College (1-4or 5+) CITY WORKER GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN TAYLOR MARY TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIAN COMMISSION ON 20b. Place of Disposition (Name of LVERT cemetery, crematory or other place) BALTIMORE, MD AGING ST_{Date} ARDIE SHAW / LEGAL GUARDIAN 20a. Method of Disposition 20c. Location - City or Town, State YSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 12/19/06 BALTIMORE, MD 22. Name and Address of FacilityHOWELL FUNERAL HOME 21207 of pneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Approximate Interval Between Onset and Death Poter the disease, or con , or heart fature. List only Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final ATHEROSCHEROTIC Physician disease o condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 € No 1 ☐ Yes a/Z No I or Attending Physician: after death. Diractor: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 27 Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ellell

Registrar

DHMH 17 Rev 1/2001

State

7220

ARK HEICHTS AVE,

DALD MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TASNEEM

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

			For	State of Marylar	-			nd Mental H	ygiene		1 01 17
			State Registrar		Ce	rtificate of L	Death		Reg. No.	005	4041/
3	Physicia	16743	Decedent's Name (First, Middle, Last)					2. Date of I Month	Day		3. Time of Death
	/Medic	al	Edward 4a. Facility Name (If not institution, give s.		loe1ker	4b. City, Town, or	Location of	Dec.		2006 County of Dea	12:24 p ^M
	Examin	er	Carroll Hospital			Westmi			10.	Carro1	
i April	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)			4 Hrs. 8 Date of 8	Birth Day, Year)		thplace (State or Foreign
	Director		215-12-7729	^{M 2□ F} 83	Yrs.	Months Days	Hours	March	14, 1		aryland
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Maryli f sho	ō	Maryland Baltimor	re		Glynd	on				1 ☐ Yes 2X No
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	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f show ta Medical Exarchier must be notified at	a D	4240 Butle	er Road			21071			U.S.A.	
	ema erm	Funeral	11. Marital Status	Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Orig n, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
36	or it		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give		1 ☐ Yes 2 ☒ No				Specify:	White
21215-0036	tural	Completed by	15. Decedent's Educ	Year or Dates: WW	16a. Dece	dent's Usual Occupa	ation		16b. Ki	nd of Business	
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212	d with giene grene	mo:	12			Superv	isor		С	& P Te	lephone Co.
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic avent, it is Mudical Evantment must be notified at once.		Nancy Ellen Voelker 20a. Method of Disposition		Place of Dispe	Butler R		Glyndon, I		1071 ocation - City or	Town, State
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V	be executed sicien and burial-transit	xan	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):						
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68	leath certificate attending physi	edi									
Вох	The law requires that the death certifica tite has been signed by the attending ph page 2 should be detached for use as th	Physician/M	230. was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		□Ectopic pregnancy				23d. Date of de	
	e deal	sicis	in the past 12 months?	4☐Pregnant at time of 9☐ Unknown		Other (specify)			-	Month	Day Year
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ij.	if or Attendated after death Director:	T.	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		treet, factory, office			n (Street ar Town, State		lural Route Number,
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	within 2 To the Complet	₩	29b. Signature and title of certifier	2 . 0 .		29c. Licens	e number		29d. Da	te signed (Mon	th, Day, Year)
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*	141		30. Name and address of person who co		_	, Print)		18 STHINS,	RE	572025	JOUL, MDZ113
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All Copies Are Legible.

6-09496	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
dward August Witte	State of Maryland / Department of Health and Mental Hygiene
1. For State	Cortificate of Doath

Edward August V		State	of Maryland		rtment of		id Mental I			
Physicia		Registrar 1. Decedent's Name (First, Middle,Las	st)		- Incate of	Douin		2. Date of Dea		3. Time of Death
Medical Exami		Edward August W						Month Decembe	Day Year er 13, 2006	0831 hrs
AT-		4a. Facility Name (if not institution, given		er)		4b. City, Town, o	r Location of Dea		4c. County of	Death
		University Hospital				Baltimore				
Funeral		5 Social Security Number 6. S	ex 7.7	Age (In yrs. Ia	ist birthday)	If Under 1 Yea		_		Birthplace (State or Foreign
Director		216-42-6132	M 2 F	61	Yrs	Months Day	s Hours N	in. 08/23	/1945	Country) Maryland
	l	Usual Residence of Decedent								
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and show	5	MD N/A		В	altimo					1 X Yes 2 No
Maryl Maryl 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?
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MD id 2 sho lith and m 27 is		Toby F. Witte-Di	X (S1S-1	•		Regina D		Date	, Marylan	d 21227 City or Town, State
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee		22. 1	Name and Addres	ss of Facility	Iubbard_	Funeral H	ome, Inc. aryland 21229
		23a. Part I. Enter the disease, or com	aliactions that solve	and the death	Do not enter t	07 Wilk	ens Aver	nue, Bal	timore, M	aryland 21229 t Approximate Interval
Physician /Medical	r 10	failure. List only one cause on e	ach line.				y, such as cardia	or respiratory ai	rest, smoot, or near	Between Onset and Death
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eco ne law te has ge 2 s	ď							perf		eath? ✓ Yes 2 No
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				of docth (It.	220)					,
10+1		30. Name and address of person who Ling Li, MD Assistant I	o completed cause of Medical Exami			et, Baltimore	, MD 21201			
	tate	9 ,	_ 32. Reģis	strar's Signatu		ands.				
Regis		31. Date filed (Month, Day, Year)	2006	A CONTRACTOR OF THE PARTY OF TH	17	1000000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** DECEMBER VG 2006 /Medical Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** John NA MORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number vrs. last birthday. 8. Date of Birth (North, Day, Year) **Funeral** Days Months 1 □ M 2**X**□ F 53 231-80-9856 7-26-1953 Director Va. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within /z rrows... ment of Health and Mental Hygiene ... ment of Health and Mental Hygiene ... ment: if item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 1 X Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 508 N. Highland Avenue 21205 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) High's 10th grade <u>Manager</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Womack Jessie Lee ဂ Marie Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any Injury or other trau Timmy Bates Son 3512 Erdman Ave.,, Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Pk. 12-21-06 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 Jon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic 6 years /Medical Due to (or as a consequence of) Examiner Declaration (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (olas a consequence of): Failu and burial-tran attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**∀** No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 🔲 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a Certifier

SORDON

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

M.D

32. Régistrar's Signature

am 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

LAM, M.O

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

600 North Wolfe Street, Baltimore, Maryland

29c. License number

00063662

29d. Date signed (Month, Day, Year)

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2006

DECEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 14, 2006 11:5MA Wimbush Matthew Lee 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**∑**M 2□F JUL 16,1943 216-42-9337 63 NC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Windsor Mill 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 21244 USA 7726 Big Buck Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: African American 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Longshoreman Maritime Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leander Wimbush Pearl Goss 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7726 Big Buck Drive Windsor Mill, MD 21244 Linda Lawson-Wimbush/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 12/18/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee C. Todd Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - Told Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE SYSTEM ORGAN FAILURE Due to (or as a consequence of) PSEUDOMONAS BACTEREMIA Sequentially first our diffure, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): COLON CARCINOMA Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 Date of Injury (Month, Day Year) 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a 28b. Time of

Physician /Medical Examiner

death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

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Department of Health ar
Important: If item 27 Is
any Injury or other trau

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Baltimore, Maryland 21215-0036

and burial-transit attending physician the as ase s detached þ signed b cate has been sit certificate funeral director, this After 1 death. 24 hours after death Funeral Director:

Examiner Physician/Medical à Completed Be Certification: To the filled in by

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

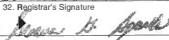
29c. License number D24034 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE TOWSON, MARYLAND 21204 LOW, 7601 TIMOTHY М. D.

31. Date filed (Month, Day, Year) State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 882 12-19-06 vt. State of Maryland Department of Health and Mental Hygiene () () () 40422 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) Month Year pmar **Physician** м Sec 2000 eorac /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** rt Heritag ste Cl JVINC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthdar) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F Social Security Number **Funeral** 20-2136 Months Yrs. BALTIMORE MI Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "netural", or itama 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Hal 77 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21086 402 death Funeral Was Decedent Ever in U.S. Armed Forces? t AYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Module 0 lectronic 17. Father's Name (First, Middle, Last) 18. Myther's Name (First, Middle, Maiden Sumame) Be mar ۵ 20120 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Jairettsville 1402 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) MD 21080 daughter Solewood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite sny injury or ot instructual Chapet Beldir 12-14-06 Forest Hill 22. Name and Address of Facility R FORES th EMAS PLACE CHAMEN COMMUNION FOREST HILL, MD 21050. Kimber 1. Battolar le 23a. Part 1. Enter the diseast, or completions that caused the death. Do not enter the mode of dying, such as circliac or respiratory arrest, shock, or heart failur. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVAS CULAR DISEASE YEARS ARTERIOSCLEROTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to influe date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physiclan/Medical detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ■Unknown HEART 2 🗆 No Completed DEMEN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be assisted 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 🗌 Yes Certification: To 6 XOther (Specify, this living 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Deat After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident filled in by the Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funarel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 250 DECEMBER ren viav MD completed cause of death (Item 23a) (Type, Print) 30. Name and address of person NORTH AVENUE MD 21014 ABHYANKAR BELAR M. 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar 9 2006 1

State of Maryland / Department of Health and Mental Hygiene 40423 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December 17,2006 8:45 A. M James Rigby Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County College Manor Lutherville tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 15, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∆**M 2□F Hours Maryland Yrs. 214-14-1220 86 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Towson Maryland Baltimore County Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Smeton Place #102 21204 United States Funeral t3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No tf Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2\OXNo Specify: þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Steel Worker Bethlehem Steel n/a permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 1e marked othe eny Injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Neva Giles William Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 Smeton Place #102 Towson, Maryland Patricia Carolyn Williams (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 23a. Party Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Ticemia Je **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Deripher attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4⊡Pregnant at time of death ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes 2 12 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) college Other: 4 Nursing Home 5 Residence 6 Other (Specify) Man Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 | Yes 2 | No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Naturat 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation efter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours e To the Funerel L 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifiei (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO 024732 emo 10 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 1 West Rd Jour Je N8 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2006

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	Dhysisi		1. Decedent's Name (First, Middle, Last)			•	2. Date of Death Month	Day Year	3. Time of Death		
	Physici /Medic		Lucy Lurlie Walter				Dec. 1	7 2006	9:45 p M		
	Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or		ith	4c. County of Death			
			Longview Nursing Home 5. Social Security Number 6. Sex	. Age (In yrs. last birthday)	Manches If Under 1 Year		s. 8. Date of Birth	Carroll	place (State or Foreign		
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Bal	permit. Pages 1 Departmant of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee		2. Name and Addres ckhardt		al Chapel	P.A.			
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	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):								
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	To the I	Σ	29b. Signature and title of certifier	`	29c. License	number	29d.	Date signed (Month,	Day, Year)		
	41		Defansitige M	<i>'</i>	DE	0110		19-	00		
	4		30. Name and address of person who completed cause m. PANSURUA 31	to waln	Sim DE	5 (M	s tmin	in set	2 41157		
	Sta Registr		DEC 1 9 2006	gistrar's Signature							

			1- State of N Registrar	/laryland		artment of F		Mental Hyg	2000	40425	
	Registrar 1. Decedent's Name (First, Middle, Last)					incate or	Dealii		Rag. No. U U U U U U U U U U U U U U U U U U U		
	Physici								er 75, 2006	5:00 PM	
	/Medic Examin		4a. Facility Name (If not institution, give street and number	th	4c. County of Death						
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	Funeral	8	1C14 2C7 C	Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) Cou	place (State or Foreign ntry)	
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	or 28	Director	10e. Street and Number			10f. Zip Code	20	11	0g. Citizen of What Cou	ntry?	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give 2 □ Widowed 4 □ Divorced	s?] Νο Γλπλ7Τ]		was Decedent of H fYes, specify Cuba 1 □ Yes 2 ☑ No	Specify:	Specify Yes or No- rto Rican, etc.)	Specify: Who	etc.	
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7	ad wit	Соп	1		Machi	nist			Steel		
Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M	Maiden Surname)		
$\frac{2}{5}$	ouid Mer Marke Marke	2	Nowell Townsend Wharton 19a. Informant's Name/Relationship (Type, Print)		10h Maili	- Add (Can-4	Grace H		City or Town, State, Zi,	- O- d-1	
<u>@</u>	id 2 si Ith an 27 is r		Carolyn Fickus (Daughter)			-			n, Virginia		
<u>ق</u>	s 1 ar f Heal item 2		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of natory or other place			20c. Location - City or T		
E 0	Page: nent o int: if		1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	(8	•	iem. Gard	· .	19,2006	Bel Air, Ma	aryland	
Baltimore,	permit. Departn imports eny inju		21. Signature of Funeral Service Licensee						Home, P.A. Ssex, Mary		
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ı	Examiner		Sequentially list conditions by Hmel hby//atem							4ylan	
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ŏ	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth	ne of pregnand		Ectopic pregnancy			23d. Date of deliv	•	
0	that the death certificated by the attending I	Physician/Me		at time of dea		Other (specify)			Month	Day Year	
JS, Р	w requires that s been signed t should be det	Part II. Date a symmount continuous continuous to death but not resulting in the diligenying cause given in Part I.							23e. Did tobacco use contribute to the ca		
S	v requ	leted						24a. Was ar		pably 4 dinknown	
Division of Vital Records, P.O. Box		Completed						autops	y prior to co	mpletion of cause of	
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ō	Phys r this ral dii	٠ <u>.</u>	exampler? 1 Yes 2 No Hospital: 1 Inpa 27. Manny of Death 28a. Date of In		R/Outpatier 28b. Time of	1 3L DOA	4 Nursing		nce 6 Other (Special Winjury occurred	(y)	
on	nding I th. : After s funer	ıtlor	1	Day Year)	Injury	Wor	k? Yes 2 □ No		,,		
ivis	p # # 프	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Roule Number of Rural Roule Number or Rur							al Route Number,	
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	the Hin 24 the Fi	Medical	(Check only one) 2 Medical Examiner: On the basis and manner	stated.	on and/or in						
)	To viti		29b. Signature and title of certifier	2		29c. Licens	1442	2°	ed. Date signed (Month,	Lay, Year)	
	H		30. Name and address of person who completed cause of	f death (Item 1	(Type	Print)	17/11	2	12/1/2/	06	
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	Sta Registr			strar's Signatu	TO A	will .					
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	Examir	ier	4a. Facility Name (If not institution, give	·			or Location of Death		4c. County of Death	
			7508 Carroll Ave		- /		undalk			imore Co.
	Funeral Director		5. Social Security Number 6. S 213-24-6023	ex YDM 2□F	e (In yrs. last birt) 79	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign intry)
			Usual Residence of Decedent		13			Sept. 4,1	.927 Mar	yland
	how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Ma Sa-1 s	cto	- 1	timore		Dundalk				1 ☐ Yes 2 🔀 No
	or 24	Dire	10e. Street and Number			10f. Zip Code	21222	10g. (Citizen of What Cou	intry?
	s 23a	stal	7508 Carroll Av		5	10 11/10			ited Stat	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If itam 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or other traumatic event. The Medical Examinat must be notified at ODGs.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Ves 2-1 If Yes, Give Year or Dates:	40	13. Was Decedent of If Yes, specify Cut 1 ☐ Yes 25 No	Hispanic Origin? (Spec ban, Mexican, Puerto F Specify:	offy Yes or No- lican, etc.)	14. Race - Amer Black, White Specify: W	
ĕ	2 hou	ted	15. Decedent's Ed	ducation	WWII 16a. I	Decedent's Usual Occu	pation	16b.	Kind of Business/Ir	ndustry
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nd	be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		en Sumame)	
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Maryland 21215-0036	nd 2 st lith and 27 Is n traun		19a. Informant's Name/Relationship (Lisa Goolsby			Mailing Address <i>(Stree</i> 508 Carrol				21222
ē,	f Heal tam		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other pla	Da	ate 20c.	Location - City or T	own, State
Ë	Page sent o nt: If		XXBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif			Ht. of Jes		/18/2006	Dundalk,	Maryland
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licer	see		22. Name and Addr Duda-Ruck	ess of Facility Funeral H	ome of Du	ndalk, Ir	nc.
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between							
	Physician		/ shock, or hearfailure. List only one cause on each line. Immediate Cause (Final disease or condition a CORONARY MRTERY DISEASE INTERPRETATION OF THE PROPERTY OF THE PROPE							
	/Medical		resulting in death)		a consequence of		E			10 (0HC)
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ŝ	res th	by	Part II. Other significant conditions of DEMENTIA. PARK				ven in Part I.		o use contribute to t 2 XNo 3 □ Pro	he cause of death?
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Vital Records,								24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
ta			25. Was case referred to medical				26. Place of Death	(Check only one)	Vo 1 ☐ Yes	2 No
	ysicii is ceri direct	o Be	examiner? 1 □ Yes 2 📉 o	Hospital: 1 ☐ Inpatie	nt 2 ER/Out	patient 3 DOA Ot		e 5 esidence	6 □Other (Special	(fv)
ō	Attanding Physician: r death. actor: After this certifics by the funeral director, i	n: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Ti	ne of 28c. Inju		8d. Describe how in		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
<u> </u>	andir eath. or: Af	atic	2 ☐ Accident investigation	1			Yes 2 □No			
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	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of the part of the pa	examination and	death occurred at the to for investigation, in my	me, date and place, ar opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as s nd place, and due t	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1		29c. Licen	se number	29d. E	Date signed (Month,	Day, Year)
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	141		30. Name and address of person who	completed cause of d	eath (Item 23a) (T)		1340141	1
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DHMH 17 Rev 1/2001

Registra

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1)80 2006 Robert E.L. Wolff, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**≥**M 2□ F 215-14-4006 85 May 9, Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Maryland Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14145 Roberts Road 21750 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 No lif Yes, Give WW II Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Machinist 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert E.L. Wolff, Sadie Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary Wolff / Son 14145 Roberts Road Hancock, Maryland 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/18/2006 Cockeysville, Maryland 4□Donation 5 tother (Specify) entombment Dulaney Valley 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licensee 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 avoluc /Medical Due to (or as a consequence of): Examiner evelyonascu Se grentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit eutoc en and Due to (or as a consequence of): Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 4□Pregnant at time of death P.O. been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Ď, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2☑No this certificate 1□ Yes spital or Attending Physician: 'hours after death.
neral Director: After this certifica y filled in by the funeral director, p Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral D The Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OPar

Registrar's Signature

2723

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12-14-2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year MARGARET L. WILLIAMS **Physician** DECEMBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 3, 1937 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F 526 46 5068 69 Yrs ARIZONA Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD. N/A 1 XYes 2 No BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be I 2900 MALLVIEW ROAD 21230 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL COURT HOUSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLOYD WILSON STELLA J. COLFMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN WARREN (daughter) 2900 MALLVIEW RD. BALTO, MD. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **X**☐ Burial 2 ☐ Cremation 3 Removal from State ARBUTUS MEM.PK. DEC. 21,2006 4 ☐ Donation 5 ☐ Other (Specify) BALTO, MD. ure of Funeral Service Licensee Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YOC 4 dai /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the ass attending plant for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i 9 Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2XNo Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1' Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiet Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 0020111

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAJA A YASH 30 (Figure 1) CES 177 BARICUAN

BALTIMOR IN) 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

frank

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g862 12-19-06 vf. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 2015 PM raul Zaknzeski 12 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Haryland Medical Center Baltimore NA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
July 5, 1952 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 ☐ F 160-46-1947 Nationa, PA 54 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at MD Carolline Denton 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Choptank Avenue Pages 1 and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 21629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **TY** No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dialysis with Heart Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Francis Zakrzeski Virgina Redys ဥ 19a Informant's Name/Relationship (Type. Print) Paul Zakrzeski, Jr. – Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Choptank Avenue Denton, Maryland 21629 permit. Pages 1 and 2 Department of Health a important: If item 27 Is any Injury or other trau Baltimore, Date 20a. Method of Disposition 200 Place of Disposition (Name of Susquehanna)

Susquehanna 20c. Location - City or Town, State 19/06 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 121 Memorial Gardens York, PA 4 ☐ Donation 🤌 ☐ Other (Specify) 21. Signature of Fungral Ser Evans Tuneral Chapel and Cremation Services-Belair 3 Newport Drive Forest Hill, Maryland21050 23a. Part 1. Enter the disease shock, or heart failure. or complic List only nons hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Ischemic necrotic /Medical Due to (or as a consequence of) **Examiner** ti billation Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons uence of) Examine law requires that the death certificate be executed burial-transit Congestive heant Due to (or as a consequence of): aftending physician for use as the buria P.O. Box 68760 Renal Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2⊠No 1□ Yes Division or Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No thours after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 19758 12 /13/2006 00 T. Le THONG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anesthesiclogy Baltimore Depontment South Greene Street MO 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC

19

2006

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0227AM December Swani Zacharias 15 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Agnes Hospita Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 218-19-9609 84 Sri Lanka 6/29/22 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 SaYes 2 □ No Director Md Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ns 23a or 2 must be n 439 S. Wickham Rd 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? r than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Sri Lankan Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w th and Mental Hygier 7 is marked other th <u>Administration</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Mariampillai Elizabeth Mariampillai 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Prince A. Zacharias / Son 4915 Wilkens Ave. Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery | 12/17/06 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 21229 3620 Wilkens Ave. Baltimore, Maryland 23a. Part1. Enter the disease, or of shock, or heart failure. List or polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemolytic Anemia **Physician** /Medical Due to (or as consequence of) Examiner Megacolon Due to as a conse uence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

31. Date filed (Month, Day, Year) State DEC 1 9 2006 Registrar

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P18617

RAGAI

29d. Date signed (Month, Day, Year) December 15,2006

		_	1 - For State Registrar	State of Maryland /	-	rtment of F			iene g. No.2006	40432	
	Physici	an	1. Decedent's Name (First, Middle, Last) G . $Thor$	mas Andrew				2. Date of Deat Month	Day Year	3. Time of Death	
	/Media	al	4a. Facility Name (If not institution, give s			4h City Town o	r Location of Death	4	7, 2006	11:20 A M	
	Examir	103 Vernon Avenue								ne	
	Funeral		5. Social Security Number 6. Sex	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign		
	Director		215-18-4583 X-2	M 2□F 87	Yrs.	20,0	1100.0	Nov. 22,		ryĺand	
	/land		10a. State 10b. County	10c. City, To						10d. Inside City Limits	
	a-feh	ctor	MD Caroline	Fede	eral	sburg				1 x y es 2 □ No	
	or 28	Funeral Director	10e. Street and Number 103 Vernon Avei	2110		10f. Zip Code	21632	11	g. Citizen of What C	ountry?	
	eath v	eral		2. Was Decedent Ever in U.S.	13 V	Vas Dacadent of H			United S		
980	be filed within 72 hours after death with the Maryland hat Hygiene. nd other than "natural", or Iteme 23a or 28a-1 ehow event, the Medical Examiner must be notified at	by	1 Never Married Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 41-43		Yes, specify Cuba	lispanic Origin? (S _I an, Mexican, Puerti Specity:	o Rican, etc.)	Black, Whi	ite, etc.	
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2	e filed v Il Hygie other t vent, in		17. Father's Name (First, Middle, Last)		Car	Salesm		ne (First, Middle, N			
<u>a</u>	Mental Mental I	To Be	Raymond T. Andr	ew				th Hast	,		
Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 le marke other treumatic		19a. Informant's Name/Relationship (Typ						City or Town, State,		
	fealth m 27 her tr		Etta Mae Andrew 20a. Method of Disposition			Vernon	N HELL TO THE	- 1000	sburg, M		
more			1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	ceme	terv. crem	atory or other place	ry 12/09		oc. Location - City or Cederalsbu	rg, Maryland	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	Eskow					uneral Hom		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between								
7	Physician		Immediate Cause (Final disease or condition resulting in death) 1 SCHEMIC CARDIOMY OPATHY ADue to (or as a consequence of): Sequentially list conditions. Sequentially list conditions.								
	/Medical Examiner										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C								
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8760,	be ex ician a burial	Ical Ex	resulting in death, Last	Due to (or as a consequenc	ce of):						
687	ficate physis the		\ d								
Вох	death certific e attending pl d for use as t	In/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea		F-1			23d. Date of de	livery	
	g o g	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year	
P.0	that the de ed by the detached		Part II. Other significant conditions con	tributing to death but not resulting	n in the un	deriving cause give	en in Part I	23e Did tob	acco use contribute t	o the cause of death?	
Vital Records,	8 G 9	d by	ABRTIC STEN	OSIS, COPD	> 17	type RT	ENSION			robably 4 Unknown	
S S S	aw requir is been s 2 should	Completed	ATRIAL FLARILL	ATION MYO	CACT	NAL IN	FARCTIO	24a. Was ar		utopsy findings available	
E E	The ate h	mo						autopsy perform		completion of cause of s 2 15 No	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	- 14 · 4 ·		-		th Check only one			
of	Physic this c	.T	1 ☐ Yes 2 No			3□ DOA Othe	4 🗆 Nulsing no		nce 6 Other (Spe	ecify)	
O	Attending Physician: r death. ector: After this certifica ector: After this certifica by the funeral director, p	tlon	12Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?				28d. Describe no	8d. Describe how injury occurred		
Division	r Attendi er death. rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R	ural Route Number,			
ā	oltal or urs aft rral Di			building, etc. (Specify)			1				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	icien: To the best of my knowled er: On the basis of examination a and manner stated.	lge, death and/or inv	occurred at the time estigation, in my op	ne, date and place, pinion, death occur	and due to the ca rred at the time, da	use(s) and manner at te and place, and due	s stated. e to the cause(s)	
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,			Maynus	2-1775ND/M	INI	DO	05.50	14	12-11	-2006	
			e and ad less of person who con	mpleted cause of death (Item 23a	a) (Type, F	Print)		A (EDIRAL		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	<u></u>	J-OUM)	NU WITVZ	1702	204470	DOWER	
	Registr	ar	DEG I of	106 \$330000	18	Woodh F					

/Medical Examiner law requires that the death certificate be executed burial-tran and physician s the burial Box 68760 as attending p Division or Vital Records, P.O. the þ signed t cate has I certificate

with the Maryland

filed within 72 hours after death

Maryland 21215-0036

r 28a-f show notified at

ural", or items 23a or Examiner must be

'natural", or

the Medical

6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

29a. Certifier

29d. Date signed (Month, Dav. Year)

MEDICAL CENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAZEN EL-SAYED LIMIVERSI

AI417643 SE17517

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

funeral director.

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ithin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu

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Hospital or Attending

2006

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			State Registrar			Cer	tificate of	Death	F	Reg. No.	.000	40404
H	Physicia /Medic		1. Decedent's Name (First, Middle, La	M. (ad	ku	us		2. Date of Dea	Day 02	2001	3. Time of Death
	Examin		Facility Name (If not institution, give	e street and number)	Cen	br	4b. Gity, Town, o	lucation of Death	md.	40.0	County of Dear	nico
	Funeral Director		5. Social Security Number 6. 5	ex 7. Age	(In yrs. last to	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Yeer)	Co	thplace (Stete or Foreign ountry)
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
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	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	ountry?
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow amportant: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow apprintly or other traumatic event, the Mactical Exeminer must be notified at Once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		'	was Decedent of h f Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Pueno Specify:	Rican, etc.)		Black, Whit	
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lary	and N ls ma		19a. Informant's Name/Relationship	• • • • • • • • • • • • • • • • • • • •	1			and Number or Ru			Town, State,	Zip Code)
€	and sealth m 27		Charles J. Adkins	- son				Delmar,	DE 19940		ostion City or	Town Chain
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687	icate physics the			d								
. Box	The law requires thet the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у		2	3d. Date of de Month	livery Day Year
<u>о</u>	thet the	/ Ph	Part II. Other significant conditions	contributing to death be	ut not resulting	g in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco us	se contribute to	o the cause of death?
rds,	w requires t been signe should be	d by	Coronamy A	ntery	Deses	222			1×	Yes 2□	No 3□P	robably 4 Unknown
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Division of	l or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not			farm, st	reet, factory, office		28f. Location (S City or Tox			ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		hysician: To the best of miner: On the basis of and manner sta	examination							
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licen	se number		29d. Date	e signed (Mon	th, Day, Year)
)	, 0		S. Veens	notes.			H5	6865		14	2/20	06
	470		30. Name and address of person who		eath (Item 23	а) (Туре.	Print)	6865'		,		
	1000		STEPHEN G	JERNA 32 Panistr	ar's Signature	, ب	DEEK	5 (tok)	to Has	7 (1)	ALCE	NTER
-	Sta	ate	31. Date filed (Month, Day Year) 5	2006	us orginature	1. As	boards?					

06-09099

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Tirhas Aria 1- For State Certificate of Death Reg No. Registian Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 0005 hrs Medical Examiner November 30, 2006 Araia Tirhas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs last birthday) Social Security Number 223–27–4606 **Funeral** Months Days Hours Director 30 1976 CountrEthiopia 2X F Nov. 3, M Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County Takoma Park Md. Mont. X_{Yes 2} No 28a-f show items 23a or 28a-f shoust be notified at once. death with the Maryland Director 10g Citizen of What Country 10f. Zip Code 10e. Street and Number #600 20912 Ethiopia 7520 Maple Avenue Funeral 14 Race - American Indian, Black, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2X No Yes Black. Give Year 1 Yes 2 No specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene Divorced Widowed Examiner ð 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than " Baltimore, MD 21215-0036 Food Service 12 Fresh Field 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be matic event, <u>Ghidei Tekle</u> Araia Isaac 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #600 Takoma Park, Md. 20912 7520 Maple Ave. Araia Isaac (Father) 20c Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date permit Pages I a
Department of He
Important: If it
injury or other t crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 12/03/06 Brentwood, Md. Other Specify: Donation 5 22. Name and Address of Facility
N. Habacon, Funeral Home,
3447 14th Street, N.W. Inc. Washington, DC 20010 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. /Medical Death a Blunt Force Injuries to Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical AMENDED physician a the burial -UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 V Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? 2 No certificate ✓ Yes 2 1 🗸 Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi 25. Was case referred to medica Be examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1. Yes ဥ 28a. Date of Injury 28b. Time of Injury 28d Describe how injury occurred 27. Manner of Death 28c Injury at Work? Certification: Nov 29, 2006 Subject assaulted 0000 hrs Natural Yes 2 V No Pending the Investigation Accident 28f Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 7520 Maple Avenue, Takoma Park, MD Suicide determined (Specify) Local Street 4 V Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Fo the and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c License numbe O.C.M.E. November 30, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31 Date filed (Month, State DEC 04 Registrar

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment of H			giene leg. No: 006	40436	
Г	Physici	an	Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		3. Time of Death	
	/Medi			HN				NOV 3	0,2006 Year	1:00P M	
1	Examir	ner	4a. Facility Name (If not institution, giv				Location of Deati	n	4c. County of Death		
			17060 #126 KI 5. Social Security Number 6. S	NG JAME	S WAY Age (In yrs. last birthday		ERSBURG If Under 24 Hrs.	[n n	MONTGO		
П	Funeral Director				73 Yrs.	Months Days	Hours Min.	(Month, Day	, Year) 9. Bii	rthplace (State or Foreign country)	
			Usual Residence of Decedent				<u> </u>	OCT 4,	1933 S	. KOREA	
	rylan	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
	Ba-f s	cto	MD MONTGO	MERY	GAITHE	RSBURG				1 ☐XYes 2 ☐ No	
	hours after death with the Maryland turel', or tlems 23e or 28a-f show al Examination notified at	al Director	10e. Street and Number 17060 #126 K	ING JAM	ES WAY	10f. Zip Code 2087	77	1	0g. Citizen of What C	ountry?	
	lterns	Funeral	11. Marital Status	12. Was Deceder Armed Forces	\$?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Am-		
36	d within 72 hours after spiene." r then "naturel", or little Medical Examination.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give	XNo	1 ☐ Yes 2 ☐ No	Specify:	, , , , ,	Specify: AS		
8	hour ture	ed b	15. Decedent's Ed	Year or Dates			ation				
5	in 72 n "nat	Completed	(Specify only highest gra	ide completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of Business	/Industry	
212	d within jiene. r then "	E O	Elementary/Secondary (0-12)	College (1-4o	r 5+)	SEWIFE	,		PRIVA	יה ת	
פַ	Hyg Hyg ent.	Bec	17. Father's Name (First, Middle, Last)		- AUU	SEMTE-E	18. Mother's Nam	ne (First, Middle, I		rr.	
/lar		To B	JUNG KWON K	IM			SOON I	ET LEE			
Maryland 21215-0036	ges 1 and 2 should to tof Health and Ment if Item 27 Is marked or other treumetic et		19a. Informant's Name/Relationship (Туре, Print)	19b. Mail	ng Address (Street a	and Number or Ru	ral Route Number	, City or Town, State,	Zip Code)	
	and sealth m 27		JOSEPH AHN /S	ON		2 GROGAN	IS CT CI	ENTREVI:	LLE VA	20121	
ore	Pages 1 ar		20a. Method of Disposition 1 SpBurial 2 Cremation 3	Removal from Stat	20b. Place of Disponentery, cre	osition (Name of matory or other place	θ)	Date	20c. Location - City or	Town, State	
Ë	ment tent: jury		' 4 □Donation 5 □ Other (Specific		NORBECK	MEMORIA			OLNEY MI		
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature Funeral Service Lio	1	2	2. Name and Addres	CHARLES	HINDS	FUNERAL	SERV	
	/Medical Examiner	ner	23a. Part1. Enter the disease, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	aDue to (or a	line.					Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying That initiated events resulting in death) Last	c. Due to (or a	s a consequence of):						
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ★10 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
S, D	The law requires that the the has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions o	ontributing to death	but not resulting in the u	nderlying cause give	n in Part I.		acco use contribute to	the cause of death?	
al Record		Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of 2 No	
Vital	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ctho		h (Check only one			
Division of	ding Phys h, After this funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D		28c. Injury Work	4 Nursing ric	ome 5 V Reside 28d. Describe ho	nce 6 □Other (Spec w injury occurred	city)	
Divisi	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At home, farm, str tc. (Specity)			28f. Location (Str City or Town	eet and Number or Ru , State)	iral Route Number,	
	To the Hospitel or A within 24 hours after To the Funerel Director Completely filled in by	edical	29a. Certifier (Check only one)	ysician: To the bes iner: On the basis and manner s	t of my knowledge, deati of examination and/or in tated.	n occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month	n, Day, Year)	
)	0.)		DOD(02236	+	12/1/06		
	By		30. Name and address of person who o	completed cause of	death (Item 23a) (Type,	Print)	<u> </u>				
	•			1.D 9707	MEDICAL	CENTER I	OR. SIIT	TE 300	ROCKVII.T	E MD 20850	
	Sta Registra		31 DEC 0 4 2006 Pear)	32. Regist	rar's Signature				THE CHAPTER	u 110 20000	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. angual of Maryland Department of Health and Mental Hygiene State Registrar Amend#23a. Prt. 1. PerPhys. PCC12-1-06cc Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Tarick 2006 November 28 0:15A /Medical Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Date of Birth (Month, Day, Year) Age / Birthplace (State or Foreign Country) **Funeral** Months Hours 1 X M 2 □ F Yrs 578-78-5784 Director 11/10/63 Alaska Usual Residence of Decedent 10c. City, Town or Location 10b. County Show 10d. Inside City Limits r 28a-f show notified at Md. Prince Georges Suitland 1 ☐ Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 5008 Suitland Rd. 20746 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black Specify: 3 Widowed 4 Divorced 72 hours Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Firefighter D.C. Fire Dept. 12 marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othwarny injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ε. Frank Lewis Kathleen Massey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica G. Ali/ wife 5008 Suitland Road, Suitland, Md. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Washington National12/1/06 4 □ Donation 5 □ Other (Specify) Suitland, Md. 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Ser Licensee sec 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Renal 2 weeks /Medical Due to (or as a consequence of) Examiner Hyperkalemia 3-5 days Sequentially list conditions, it any, bearing to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9□Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an page 2 s autopsy performed: certificate | Division or Vital 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 28,2006 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BaHIMORE The Johns Hapkins Haspital, 600 North Wolfe Street, Maybre 2108 32. Registrar's Signatur State Registrar

06-09389 Milkey Abay

lilkey Abay		1- For State Registrar		ate of Maryla		rtificate o			ivientai		Reg No	200	5 40431	
Physicia Medical Exami		1. Decedent's Nam-								2. Date of D Month Decemb		Year	3. Time of Death 1602 hrs	
		4a Facility Name (i		on, give street and nun	nber)			own, or Lo	cation of D	eath		c. County of Deat	h	
Funeral Director		5. Social Security N 215-77-021	lumber	6. Sex	7. Age (In yrs.	last birthday) O yrs	If Unde	r 1 Year	If Under 24 Hours	Min. Novemb	Birth(MM	/DD/YYYY) 9. 8i Forei		
any		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Locat	ion						10d. Inside City Limits	
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ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Nur		+ N1 #01	2		10f. Zip					izen of What Cou	intry?	
with the ms 23a o	uneral D	11 Marital Status		A	dent Ever in U			nt of Hispa		(Specify Yes or I	USA No-		rican Indian, Black,	
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hours a natura Examir	ed by			cify only highest grade		16a. Deceder during m			n (Give kind O NOT use		16b. I	Kind of 8usiness/	Industry	
036 ithin 72 ne r than " tedical J	ompleted	Elementary/Seco	ondary (0-12)	College (1-	4 or 5+)	Neve	er Worl	red		,		None		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name Abay Box		, Last)				18		ame (First, Middle ula Abde B				
D 2121; should be fill and Mental H 'is marked	2	19a. Informant's Na				1.0				or Rural Route N				
e, MD I and 2 sho Health and item 27 is		Abay Boga 20a. Method of Dis	position			Place of Dispos	sition (Nam			#213, Silv Date		ring, MD 2 Location - City or		
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Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility rancis J. Collins Fune: 00 University Blvd, W,									Inc.			
Physician /Medical		23s Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.											Approximate Interval 8etween Onset and	
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8760, tificate be ng physic as the bur		IF FEMALE. 23b. Was decedent		23c. If yes, o	utcome of preg	gnancy	tal death	3	Ectopic pre	egnancy	230	d. Date of deliver	y Day Year	
Box 68760, re death certificate be executed the attending physician and ned for use as the burial - transit	ysician/	past 12 months		known 9 Unknow	ant at time of de wn	oath	her (Spec	ify)			1000			
ries that the signed by the detached	by Phy	Part II. Other signi	ficant condit	contributing to	death but not r	resulting in the u	underlying	cause give	en in Part I.		,	use contribute to	the cause of death?	
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ital Reccician: The lav	Com	25 Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Normal Place of Death (Check only one) 1 Yes 2 No 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred.											es 2 No	
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Division of Vital Records, P.O. Box 68760, vithin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	ertification:	2 Accident 3 Suicide 4 Homicide	Inve	stigation	of Injury - At h	nome, farm, stree	et, factory,	office buil	ding, etc.	28f. Location or Town		and Number or Ru	ural Route Number, City	
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To To	Me	29b. Signature and	title of certific	and manner sta	1		29c.	License r				Date signed (Mo		
		30. Name and addr	ess of persor	who completed cause	e of death (Iten	n 23a)		J.O.IVI.			The c		-	
		Susan Hoga	an MD.	Assistant Medica	al Examine	r 111 Pen	n Stree	, Baltim	ore, MD	21201				
St	ate	31. Date filed (Mont	th, Day, Year)	7006 32 Reg	gistrar's Signat	The son	A S							

06-09298	
Juma Ada	ams

Juma Adams		1- For State Registrar	tate of Maryland	•	ficate of			Reg. No. 200	6 4043	
Physicia Medical Examin		Decedent's Name (First, Midd Juma Adams					2. Date of De Month Decemb	eath Day Year er 6, 2006	3. Time of Death 0545 hrs	
and halle		4a. Facility Name (if not institution Prince George's Hosp	on, give street and number	r)	4t	. City, Town, or Location		4c. County of Dea		
Funeral		5. Social Security Number		ige (In yrs, lasi	t birthday)	Cheverly If Under 1 Year If U	der 24Hrs. 8. Date of E	Prince George's f Birth (MM/DD/YYYY) 9. Birthplace (State or		
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0036 within iene ner thau	팂	12]	Proper	ty Manage		Private		
	Be C	17. Father's Name (First, Middle, James Adams	Last)				er's Name (First, Middle ette Vauc	,		
bould by Meny is mark		19a. Informant's Name/Relations			19b. Mailing A	ddress (Street and Nu	Imber or Rural Route Nu	umber, City or Town, Stat	e, Zip Code)	
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	1	Fayette Vaug	hn-Lee/mo		Washi ce of Disposite	ngton, DC on (Name of cemetery,	20003 Date	20c. Location - City o	r Town State	
Baltimore, M Permit Pages 1 and 2 Department of Health Important: If item 2		1 X Burial 2 Cremation		state cre	matory or othe	place)				
Baltimo permit Pag Department Important: injury or ot	1	4 Donation 5 Other St. 21 Sig ature of Funeral Service		Line	ZOLN M 22. Nar	em. Cem. ne and Address of Facili	112/13/06 By Hodges &	Suitlan Edwards	<u>а, ма</u> Е.н.	
1	4	23a art I. Enter the disease, or	complications that cause	d the death D	391	0 Silver	Hill Rd.,	Suitland	, Md.20746	
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6 be executed sysician and burial - transit	Medical	UNPENDED	x AMENDED 5	per fl	n g862	12-19-06 vt				
3760, ificate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outco	ome of pregnar		death 3 Ectop	ic pregnancy	23d Date of deliver	y Day Year	
Box 687 e death certific the attending p	Physician/	past 12 months? 1 Yes 2 No 9 Unk	4 Pregnant a	at time of death	_ =	· (Specify)	по ргедпаноў	MOINT	Day fear	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death and Director: After this certificate has been signed by left in the lamenal director, page 2 should be detacted.	ed by							es passer a re	bably 4 Unknown	
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ting Ph	Ë	27. Manner of Death	28a. Date of In	jury 28 Year) F	Bb. Time of Inju		Subject she	how injury occurred		
ivisior f or Attend after death Director:	läti	2 Accident Inves	Stigation Dec 6, 2006	0	510 hrs	1 Yes 2 V	No	(Street and Number or Ru	rel Pouto Number City	
Div	Certification:		d not be (Specify) Lo		o, raim, ocroot,	actory, office building, e		State) Vashington, DC	dial Route Number, City	
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F > F 3	ğ	29b. Signature and title of certifie				29c. License number		29d Date signed (Mo		
		Alha Blus	ull, MID	doub /lic 00		O.C.M.E.		December 7, 20	06	
		 Name and address of person Melissa Brassell, MD 	Assistant Medica	,	*	nn Street, Baltimor	e, MD 21201			
Sta	te	31. Date filed (Month, Day, Year)	2006 32. Pojisto	ar's Signature	1	AV o				
Registr	ar	DEO 1 s	LUUU ASSA	ARD SS	Apan	al constant				

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygien Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Brvner 3,2006 December /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lions Center for Rehabilitation Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Day, Feb 23, Birthplace (State or Foreign County) Funeral 1 □ M 2 🛛 F 218-30-0388 74 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other then "neturel", or Items 23e or 28a-f show other treumatic event, the Madical Examination in Additional Allegany MD Cumberland Be Completed by Funeral Director Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Lafayette Avenue 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No **¾**□ Widowed 4 □ Divorced Specify: white 15. Decedent's Education
(Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within in and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Sryner homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph Wright Nellie Marie Wright Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1918 Koontztown Falling Waters WV 25419 19a. Informant's Name/Relationship (Type, Print) t of Health a: If item 27 Is Ralph Bryner son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Eckhart Cemetery ö 12/18/2006 Eckhart tment MD injury (`4 ☐ Donation 5 ☐ Other (Specify) permit.
Departn
Importe
any inju 21. Signature of Funeral Service License 22. NarScarpellis Puriellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Advunced Dement 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniforming Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 (4) Due to (or as a consequence of): attending physician by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐ Pregnant at time of death Month Day 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 1 ☐ Yes 2 📉 No Other: this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of I Director: After to in by the funera Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) worsockeller MO 00055325 Dec 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCIC 48 Turn SHIN MD Terrace Frostburg MD 21532 31. Date filed (Month, Day, Year) 32. R istrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 11. Donald Lewis Bubb, Sr. 2006 8:03F 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Saint Joseph Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 XM 2 □ F 215-32-7771 72 Oct. 15, 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore Parkton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1507 Armacost Road 21120 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Unknown 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Lewis Bubb Naomi Shaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise M. Bubb 1507 Armacost Road, Parkton, MD 21120 20b. Place of Disposition (Name of cometery, crematory or other, place)
Pine Grove United Methodist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkton, MD 4 ☐ Donation 5 Other (Specify) 2006 22. Name and Address of Facility J.J. Hartenstein Mortuary, Ind. Curlu24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC PROSTRATE CARCINOMA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 2 No 3 Probably 4 Unknown 1 Tes CEREBROVASCULAR ACCIDENT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 mpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical once.

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Baltimore, Maryland 21215-0036

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29b. Signature and title of certifier

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certificate has Physiclan; funeral director, After this Hospital or Attending n 24 hours after death.

le Funeral Director: / death. completely within 2

DHMH 17 Rev 1/2001

Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

≒ rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

DØØ17695

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

HELOU M. D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JOHN HAMILTON BRIMER 12 02 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Regional Salisbury Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 217-36-2149 88 Director 10/02/1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester 1 Yes 2 No Girdletree 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1915 Snow Hill Road 21863 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: SpecifyWhite à 3 ₩idowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Management State Goverenment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Brimer Laura Virginia Dryden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis B. Trader/ daughter P.O. Box 101 Girdletree, MD 21863 permit. Pages 1 and 2 Department of Health an important: if Item 27 is any injury or other trau <u>once</u>. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Spring Hill Cem. 12/07/2006 Girdletree, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home, Professional Association 23a. Part I. Enter the disease, or complications that caused the death. Do not enter hims 1 Arg. su 1000 page 7 certain MD e21851 shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 TXER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural nerei Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-06-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 S. DIVISION ST. SAUSBUM RA6 V. ANUPAMA 10.0. 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State DEC 0 6 2006 Registrar

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DHMH 17 Rev 1/2001

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of the	Physici /Medio		Patricia Beacl	n	12	1 200							
4	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or in: one)	vestigation, in my opinion, death occurred	at the time, date	and place, and due	to the cause(s)						
	To th within To th comp	₩	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Mont	h, Day, Year)						
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	4 m		30. Name and address of person who completed cause of death (Item 23a) (Type.	Ha050773		4/	200						
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		-	Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of Death	2. Date of Death	g. N6:- 0 0 0	3. Time of Death
	Physici /Medic		Thomas Henry Boyd				Month	Day Year bel 03.2	B
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or Location of Dear		4c. County of Deat	
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	Funeral		5. Social Security Number 6. Sex	M 2 T F	Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
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	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at		Paula Boyd / Daught		554 K	Knightsbridge Dr.			
Baltimore	permit. Pages 1 and 2 Depertment of Health Important: If tem 27 eny injury or other tra ance.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Regression	emoval from State 20b. Place cemet	of Dispo: tery, cren	sition (Name of natory or other place)	Date 2	Oc. Location - City or	Town, State
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89	nutifica ing ph	Physician/Medi	IF FEMALE:						
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		Ectopic pregnancy		23d. Date of deli Month	very Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 9 ☐ Unknown	5∟	Other (specify)			
, P.O	res thet the de signed by the e be detached t	y Ph	Part II. Other significant conditions con	stributing to death but not resulting	in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
of Vital Records,	w requires been sign should be	ed by	of the Bull and a section of				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Munknown
ဝ၁	e law requ has been je 2 shoult	Completed					24a. Was an autopsy	24b. Were au	topsy findings available
<u> </u>	The la	Com					performe	ed? death?	
Vita	ysicien: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	ospital:		Other	ath (Check only one)		
to	S S D	2	1 ☐ Yes 2 ☐ No H	Inpatient 2 EPVC	Outpatient Time of		fome 5 Residen	ce 6 Other (Spec	cify)
on	th. : After	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	20d. Dodorioo rion	milary occurred	
Division	f or Attendi efter death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru	ral Route Number,
ā	Ital or rs eft ral Dir led in	Cert	/	building, atc. (Opacity)			Ony or rown,		
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certifical completely filled in by the funeral director,	Medical	(Check only 2 Medical Examin	ner: On the basis of examination a	ge, death and/or inv	occurred at the time, date and place estigation, in my opinion, death occurrence	e, and due to the cau	ise(s) and manner as e and place, and due	stated. to the cause(s)
	ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	290	d. Date signed (Monti	n, Day, Year)
	ĕ → S → ŏ		Mausai	g suop		D28365		12 . 4 -01	
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, i	Print)			
الإ	4-5+1		MANZAR	J SHAP136	8 n	ull Street Ha	gesterni	4021	740
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		P. M.	J		
	negisti	ul	HEU U O ZU	UU Marcens St.	138	T. A. C. C.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.0.0.0

	1 - For State Registrar	otate of waryland / i	Certificate of Death		Reg. No.	40440
Physician /Medical	1. Decedent's Name (First, Middle, La	BROWN		2. Date of Dea Month	Day Year	3. Time of Death
Examiner	4a. Facility Name (If not institution, given	re street and number) HOSP/TAZ	4b. City, Town, or Location of DETHES BR	Death M	4c. County of Dear	
Funeral Director	5. Social Security Number 6. S 282-26-2672 Usual Residence of Decedent	Sex 7. Age (In yrs. last bii M 2□F 76		Hrs. 8. Date of Birth Min. (Month, Day July 15	year) 9. Bin Co 0, 1930 Ohi	thplace (State or Foreign buntry) .O
ehow	10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
the Maryla	Maryland Montgon	nery North	Bethesda			1 ☐ Yes 2 🙀 No
6 after death with the Mar after death 23a or 28a-1 e didef must be notified Funeral Director	10e. Street and Number 10400 Strathmore	Park Court #202	10f. Zip Code 20852		log. Citizen of What Co United Sta	
death w me 23a Count	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		14. Race - Ame	rican Indian,
aryland 21215-0036 should be filed within 72 hours after death with the Maryland of Mental Hyglene. Individual Hyglene "natural", or itema 23a or 28a-f show manic event, the Medical Evant internal the notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 ₹ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, F	uerto Rican, etc.)	Specify: Wh	e, etc. iite
n 72 h n 72 h 'natu	15. Decedent's E (Specify only highest gr		Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/	Industry
ind 21215-003(be filed within 72 hours a fall Hyglene. d other natural; o event, the Madical Exam Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ F	Research Scientist		Electrica	.1
nd 2 be filed d other event,	17. Father's Name (First, Middle, Last			Name (First, Middle, I	Maiden Sumame)	
ryla hould I d Men narke	Bernard Robert Bi	12.1. 19.12.12. I		Garfinkle		
ore, Maryland 2 es 1 and 2 should be filed of Health and Menlat Hygi filen 27 is marked other r other treumatic event. To Be Cc	Shirley F. Brown		Mailing Address (Street and Number of 1400 Strathmore Par	r Hurai Houle Number ck Ct. #202	r, City or Town, State, 2 2, N. Bethe	sda, MD
Pag ment uny o	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ 4交 Donation 5 ☐ Other (Specia	Triginovas nom State	Disposition (Name of ry, crematory or other place) gacy Foundation 20	c. 3,	20c. Location - City or Tucson, Ar	
Balt permit. Departr importr any inju	21. Signature of Funeral Service Lice	The second secon	22. Name and Address of Facility Thibadeau Mortua 933 Gist Avenue,	ry Service	, P.A.	
	23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter the mode of dying, such as car			Approximate Interval Between
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a END STAGE		EASE		Onset and Death
Evaminer	1	Due to (or as a consequence	of):			
28 Figures	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):			
68760, rificate be executed og physician and as the burial-transit	that initiated events resulting in death) Last	c. KEFRACTOR Due to (or as a consequence	y HYPOTENS	(0 N		
		d				
	IF FEMALE:	23c. If yes, outcome of pregnancy			201 8-11-11	
P.O. Box 6876 that the death certificate be ed by the attending physicia detached for use as the bur Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year
5, 8 8 8 y	Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause given in Part I.		pacco use contribute to	V
pie as the				24a. Was ar autops perform 1 Yes 2	y prior to c death?	topsy findings available completion of cause of
of Vital R. Physician: The Physician: The rail director, page : To Be Com	25. Was case referred to medical examiner?			Death Check only one		2 140
of Vita Physician: rithis certific ral director.	1 ☐ Yes 2 No 27. Manner of Death			g Home 5 Reside	nce 6 Other (Spec	ıfy)
ion of ion of ion of ion of ion of ion of ion or ion of io	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	ime of njury at Work? M 1 Yes 2 No	28d. Describe no	w injury occurred	
Jack Division of Division of Ital or Attending F is after death all Director: After led in by the funeral Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
Division o Division o To the Hoepital or Attending Ph within 24 hours after death To the Funeral Director: After it completely filled in by the funeral Medical Certification;	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	, death occurred at the time, date and pl d/or investigation, in my opinion, death o	ace, and due to the ca ccurred at the time, da	luse(s) and manner as ate and place, and due	stated. to the cause(s)
To t with To t	29b. Signature and title of certifier	Zlave Tier	29c. License number	29	9d. Date signed (Month	, Day, Year)
20	30. Name and address of person who	1 My Si Tuan	D64721		12/2/06	
90	Kandavelan Viswal	ingan, M.D., 8600	Old Georgetown Ro	ad, Bethes	da, MD 208	14
State Registrar	31. Date filed (Month, Day, Year) DEC - 4	32. Registrar's Signature	boods			

			1 - For State Registrar	State of Ma	aryland / D	epartm Certific	ent of F ate of	lealth ai <i>Death</i>	nd Ment			5 1	+0446
			Decedent's Name (First, Middle, Land)	nst)				Death	2. D	ate of Death	g. No.	3	Time of Death
	Physici		David E Bo	wers					N.	Aonth		224	6:35 p ^M
	/Medic Examin		4a. Facility Name (If not institution, gi			4b	City Town o	r Location of		VCIIIDCI	4c. County of		0.33 p
	Examin	er	Fox Chase Rehab		na Conta								
H	Funeral				e (In yrs. last birti	day) If U	nder 1 Year	Spring If Under 24	4 Hrs. 8. D	ate of Birth	Montg		(State or Foreign
	Director		578-20-3483	1⊠M 2□F	95 Y	rs. Mor	ths Days	Hours	Min. (A	Month, Day, pt. 13	Year)	Country) Marv	
	ס		Usual Residence of Decedent						100	pt. 13	,,1,11	riary	Land
	how		10a. State 10b. County		10c. City, Town	or Location						10d. la	nside City Limits
	e Ma	cto	Maryland Montg	omery	Silve	r Spr	ing					1	Yes 2 No
	th th	Director	10e. Street and Number			10	. Zip Code			10	g. Citizen of Wha	t Country?	
	23a	a	2015 East West H	ighway			20910)			United S	States	5
	r deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was D	ecedent of H	lispanic Origi an, Mexican,	in? (Specify) Puerto Rican	res or No-	14. Race -	American In White, etc.	ndian,
2	or It	by F.	1 XNever Married 2 Married	1 ☐ Yes 2 🔀! If Yes, Give	No		s 22 No	Specify:		,,	Specify:	ville, etc.	
3	ural'		3 Widowed 4 Divorced	Year or Dates:								White	
5	n 72	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>de completed)</i>	16a. i	Decedent's 'Give kind o	Usual Occup f work done	ation during most o d)	of working		6b. Kind of Busin		
7	withi	Ę	Elementary/Secondary (0-12)	College (1-4or 5	1+)		Attend			1	brary of	_	
V	Hygie ther nt.		17. Father's Name (First, Middle, Las	5+		Deck	Accend		s Nama /Fire		Federal	Gover	rnment
<u>a</u>	ntal ed o	Be		,							•		
	hould d Me mark matic	ဥ	John E Bowers 19a. Informant's Name/Relationship	Tuna Briat	105	Mailine Ada	(04		nces L				
2	d 2 s th an 7 is i										City or Town, Sta		•
บ	1 an Heal em 2 ther		Richard McNally 20a. Method of Disposition	/ Guardian	20b. Place of I			treet	, KOCK		Marylar Oc. Location - City		
2	ages nt of .: If it		1 ⊠ Burial 2 ☐ Cremation 3 [cemetery	, crematory	or other plac	, I					
	rtmer rtant		4 Donation 5 Other (Special		Ft. Lin						rentwood		
<u> </u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Ergin and must be collised at once.		21. Signature of Funeral Service Lice	nsee		Simp1	e and Addres e Trib	ss of Facility oute Fu	uneral	and C	remation	n Cent	er
	48200	\dashv				1040	ROCKVI	TIE F	ike, K	ockvil	ie, Mary	yland	20852
			23a. Part 1. Prier the disease, or con shock of heart failure. List only	one cause on each lin	the death. Do no ne.	ot enter the	mode of dyin	g, such as ca	ardiac or resp	oratory arres	t,	Inter	roximate rval Between
	Physician		Immediate Cause (Final disease or condition	a. Pneumon	ia								et and Death week
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	A	_	Sequentially list conditions,	b									
_	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						-	
	and I-tran	Хап	that initiated events resulting in death) Last	C. Due to (es es	a consequence of								
,	cien cien ourial	E		Due to (0) as	a consequence of):							
0	icate be executed physicien and the burial-transit	dlcal		d								112	
⊃ ≺		a	IF FEMALE:	23c. If yes, outcome	of 0.0000000								
2	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth	2 Fetal death		ic pregnancy				23d. Date of Month	delivery Day	Year
5	the de	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 Othe	(specify)					Suy	· oui
	that the sed by detac	문	Part II. Other significant conditions	contributing to death by	at not resulting in t	ha undarki	no cauco one	on in Port I	2	3a Did toba	cco use contribut	to to the ser	unn of death?
Ŝ	or Attending Physician: The law requires that the death certit that death. Differ death. Differ of this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	d b	Atherosclerotic			and directly i	ig cause give	371 H71 Q7C 1.	-		2 □ No 3 □		
5	w requir been si should	etec			ase	····					20140 30	Trobably	4 ETOHKHOWN
ב	e law has b	Completed	_Atrial Fibrillat	ion					_ 2	4a. Was an autopsy	24b. Were prior	autopsy fin to completi	ndings available ion of cause of
=	ding Physician: The I h. After this certificate ha funeral director, page	ខិ	Hypertension						1	performe ☐ Yes 2		h? Yes 2⊠il	No
	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Lionnitel.			Tou		f Death (Che	ck only one)			
5	Phys this al dir	၉	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie				4 LZLINUISI			ce 6 □Other (5	Specify)	
	ding f	<u>ö</u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tir <i>Year)</i> Inji	шту	28c. Injury Work		i	escribe how	injury occurred		
2	r Attend er death rector: by the f	cat	2 Accident investigation 3 Suicide 6 Could not be			M		Yes 2□No					
-	or Al	ertification;	4 Homicide determined	28e. Place of Inju	ıry - At home, farn c. (Specify)	n, street, fa	ctory, office		28f. Lc	ocation (Stre ity or Town, .	et and Number o State)	r Rural Rou	te Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	20a Caddiar . EZ C	U	4 1								
	To the Hospital within 24 hours a To the Funeral i completely filled	edical	29a. Certifier 1 🕅 Certifying Pl (Check only 2 Medical Examone)	nysician: To the best of	examination and/	death occur or investiga	red at the tim tion, in my op	ne, date and p pinion, death	place, and du occurred at t	e to the cau he time, date	se(s) and manne a and place, and	r as stated. due to the c	ause(s)
	thin !	Med	29b. Signature and title of certifier	and manner sta	ted.		29c. License						
	₽¥₹8		No.							290	. Date signed (M	onui, Day, 1	rodi)
	1		-112	•			D286	56			November	30,	2006
	'		30. Na u so person who					_					
,			Ravi Passi, M.D 31. Date filed (Month, Day, Year)		ond Aven: ir's Signature	ue #4)4, Si	Iver S	pring.	Mary	land 209	10	
	Stat Registra		DEC - 4	2006	J Signature	Lovel	9						

	1 = For State Registrar		epartment of Health and Certificate of Death	d Mental Hygien	2000 40447
	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Di	av Year 3. Time of Death
Physician /Medical	Joan Patricia	Bernardi Cassil	ly	December 8	
Examiner	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of De	eath 4	c. County of Death
	2812 Belcamp Road		Aberdeen		Harford
Funeral	5. Social Security Number 6. Sex	M 20XE	nday) If Under 1 Year If Under 24 Hours Months Days Hours M	in. (Month, Day, Year	9. Birthplece (State or Foreign Country)
Director	213-40-1447 Usual Residence of Decedent	64	13.	12/07/200	6 Maryland
land	10a. State 10b. County	10c. City, Town	or Location	· . • · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
Marylan f show	MD Harkord	Aber	doon		1 ☐ Yes 2 🛣 No
the notified	10e. Street and Number	7,000	10f. Zip Code	10g. C	itizen of What Country?
3a o	2812 Belcamp Road	North	21001	u.	S.A.
of the man with the Mar where the control of the co	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pa	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
Por Ite	1 ☐ Never Married 2 ▼ Married	1 ☐ Yes 2 [X] No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	ono moan, etc.)	Specify: White
ours a ours a d bv	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	13.103.220.10		
ed within 72 hor ygiene. her than "nature t, the Medical E.	15. Decedent's Educ (Specify only highest grade	cation 16a. I	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 16b.	Kind of Business/Industry
Mithin 16.	Elementary/Secondary (0-12)	College (1-4or 5+)	Librarian		ibrary
Hygie nt, mr, Co		U		Name (First, Middle, Maide	
hould be filed within the Mental Hygiene. marked other than matic event, traffic. To Be Compi	7 . 1 . 71	rnardi.	Alic	e Frances St	out
ite; Mal ylail of 12.13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel; or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type		Mailing Address (Street and Number or	Rural Route Number, City	or Town, State, Zip Code)
MG 2 state and 2 s	Peter B. Cassill	u (Husband) 2	812 Beleamp Road N	outh Aboute	on MD 21001
thea thea other	20a. Method of Disposition	20b. Place of	Disposition (Name of r, crematory or other place)	Date 20c. I	Location - City or Town, State
Pages nent of int: If It	1 Burial 2 □ Cremation 3 □ R *4 □ Donation 5 □ Other (Specify)		in Cemetery 12	/13/2006 Hav	re de Grace, MD
교 교육원중	21. Signature of Funeral Service License		22. Name and Address of Facility F MCChell-Smith F	unonal Hama	D A
Dermi Depart Import	Mara C.	Bellman	123 S Washingto	unetae nome,	uno do Grano MD
*2	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do n	ot enter the mode of dying, such as care	diac or respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Brent C	aucos & M	otrollas	Onset and Death
/Medical	resulting in death)	Due to (or as e consequence of	Coff Coff	coron to be	
Examiner	Sacuentially list conditions	RECITION			
executed in and ial-transit	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of	f):		
ami trans	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	4).		
		Due to (or as a consequence of	1).		
cate be e		l			
ding	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery
the death certification of the attending ached for use as a hystolean/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
the de sched	1 Yes 2 No 9 Unknown	9 Unknown	o di ottor (spoony)		
w requires that the death certific been signed by the attending probe of the control of the cont	Part II Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
The law requires that The law requires that ale has been signed b age 2 should be deta				1 ☐ Yes	2 No 3 Probably 4 Unknown
law requires law requires as been sign 2 should be				24a. Was an	24b. Were autopsy findings available
The law requires the law requires the law requires the law requirements the law requirements the law requirements the law representations of the law represe				autopsy performed?	prior to completion of cause of death?
			26 Place of	1 Yes 2 4	No 1 Yes 2 No
93 (A = C	examiner?	lospital: 1 Inpatient 2 ER/Out	Othos	ng Home 51 Pesidence	6 ☐Other (Specify)
ding Phy h. After this funeral c		28a. Date of Injury 28b. T	ime of 28c. Injury at	28d. Describe how in	
ISION ttending death. ttor: After the fune	1 Natural 5 Pending 2 Accident investigation	(Month, Day 18a)	njury Work? M 1 □ Yes 2 □ No		
DIVISION Of the noting Partier death. I Director: After d in by the funeration of the funeration.	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
Lal or A is after ed Direc	1 (Donaing, etc. (epechy)			,
To the Hospital or At within 24 hours after To the Funerel Direc completely filled in by	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of my knowledge	, death occurred at the time, date and pat/or investigation, in my opinion, death of	lace, and due to the cause	(s) and manner as stated. Indicate, and due to the cause(s)
To the H within 24 To the F complete	one)	and manner stated.			
To t To t	29b. Signature and title of certifier	111)	29c. License number	[]	Date signed (Month, Day, Year)
	A / Xu	1011	1000		(11/100
8	30. Name and address of person who co	impleted cause of death (Item 23a)	Type, Print)	1 Harm	do Gomo Mr
	31. Date filed (Month, Payr Year)	32. Registrar's Signature	Porate y	July 1.	- 1000
State	10-6-19	ZUUD Literar S.	Marie Contraction of the Contrac		21010

Bartlett Cottrill Sa. Facility Passe (from restriction, your sized and number) Sa. Facility Passe (from restriction, your sized and number) Sa. Facility Passe (from restriction, your sized and number) Sa. Facility Passe (from restriction, your sized and number) Sa. Facility Passe (from restriction, your sized and number) Sa. Social Security Number (a Security Number Control Passe) Function Funct				For State Registrar	State of Maryland /		tment of Healificate of De			en o 0 0 (5 40448)
Barrlett Cottrill 4. Ratelly have in frame inflations, year was set of number) 5. Set of Security Humber in Easter and Security and S		Π.		1. Decedent's Name (First, Middle, Las	t)						3. Time of Death	
Security Number Security Num				Bartlett Cot	trill				Decembe	r 12 20		1
S. Does a Securety Name Color 233-50-51 10 M 7 7 7 7 7 7 7			_				,,			4c. County of D	eath	
Directory 233-50-285 MM P 72 Vrs. Months Days Nours Mn March 11,1934 Richwood, MV						irthday)			P. Dato of Righ			
Usual Residence of December 100, Discovery 100				1	77 M OF F			Hours Min.	(Month, Dey,	Year)	Country)	y i
Security of Programs Security		.0101							nai en Ti	, 1754 K.	Lenwood; WV	
Security of Programs Security	ırylan	ia d		10a. State 10b. County	10c. City, Tov	wn or Loca	ition				10d. Inside City Limits	
Security of Programs Security	se Ma	affic	cto		gany C	umbe						
Security of Programs Security	with th	20							10	g. Citizen of What	: Country?	
Security of Programs Security	eath y	Bust	erai			13 W		anic Origin? (Spe	city Yes or No-		American Indian.	
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Check only one) Check only one) Check only one)	spitel	filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledg	ge, death o	occurred at the time.	date and place, a	nd due to the car	use(s) and manne	r as stated.	-
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	To th	dwoo	ž	29b. Signature and title of certifier	7		~		29	d. Date signed (M	onth, Day, Year)	
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	1	Q					,	<u> </u>				
George Hennawi, M.D. 925 Bishop Walsh Road Cumberland, MD 21502			(p Wal	sh Road	Cumberla	ind, MD	21502		
State State Sta	R	Sta egistr		31. Date filed (Month, Day, Year) DEC 19 2	006 registrar's Signature	1900	ACL!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jack Joseph CLARK, Sr. 5, 2006 6:55 a. December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days 1 ☑ M 2 ☐ F Yrs. 67 June 9, Director 213-36-5052 Maryland Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "netural", or Items 23s or 28e-f show other treumatic event, the Medical Examitrar is ust be notified at Hagerstown 1 X Yes 2 □ No Directo Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 711 Knightsbridge Dr. #5 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 图 Yes 2 □ No 1958— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other then "netural", or Ite 1 Never Married 2 Married altimore. Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1959 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) V. P./Treasurer electrical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Pritchett Kathryn Pawlik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Clark - wife 711 Knightsbridge Dr. #5, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ Hagerstown Crematory 12/8/06 Hagerstown, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME tred LiVister 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ankimson disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 1 mcm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2□-No Hospitel or Attending Physicien: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 🗌 Accident 3 🗋 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1215 106 7060396 1126

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

Harstour

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNSHED

DEC 0 8 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Timothy Lawrence November 30, 2006 a 1:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise House Rockville er 1 Year | If Under 24 Hrs. Montgomery

9. Birthplace (State or Foreign Country) If Unde 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months Min. 1 ☐ M 2 ☐ F Yrs 220-34-3358 68 Washington, DC July 27, 1938 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√☐ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Baltimore Road 20850 LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 1 Yes 2 □ No If Yes, Give Year or Dates: 1961 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: White <u>გ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Bartender Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Timothy Lawrence Cox Mary Virginia ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 West Jefferson Street, Rockville Maryland 20850 of Disposition (Name of Date 20c. Location - City or Town John Roth, Esquire/Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2006 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tro-tate Cancor
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【XUnknown Completed 24a, Was an Were autopsy findings available prior to completion of cause of performed death? 1 ∐ Yes 2□No 1☐ Yes **≵**□ No 25. Was case referred to medical Be 26. Place of Death Check onl one P 27. M Certification: 2

burial-transit death certificate be executed P.O. Box 68760 physician the. for use signed by the a d be detached f Division or Vital Records. page 2 should been certificate this

funeral director, al or Attending P s after death. After filled in by

Funeral

Director

r 28a-f show notified at

d other than "natural", or items 23a or event, the Medical Examiner must be

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, tt

Physician

/Medical Examiner

Maryland 21215-0036

Baltimore,

72

To the Hospital or within 24 hours af To the Funeral D 0+1

∐Yes 2∐X0No		Hospital: 1 ☐ Inpatio	ent 2]ER/Outpatient	3 🗆 1	DOA Ot	her: 4	Nursing H	ome 5 ☐ Reside	ence	6 □Other (S	pecify)	
Accident	Pending investigation			28b. Time of Injury	M	28c. Inju Wo 1 [2 □ No	28d. Describe ho	ow inju	ry occurred		
☐ Suicide 6 ☐ Could not be determined		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Si City or Town	treet ar n, State	nd Number or e)	Rural Route	Numbe

(Check only one)	2 Medical Examine

29a Certifier

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

an. aig	nature and title of c	
•	XC	Harry

29c. License number 29d. Date signed (Month, Day, Year)

D35792

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

November 30, 2006

State

Medical

50 W. Edmonston Drive, Rockville, MD 20850 Swaroop Rao, M.D

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g863 1-4-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1/26 7 2006 Stanley B. Cohen 11:03A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Collingswood Nursing Home Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Director 081-19-3802 81 9/29/1925 NY Usual Residence of Decedent permit. Pages 1 and 2 sho id be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Montgomery Bethesda 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7600 Marbury Road 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify ð Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 5+ College (1-4or 5+) Elementary/Secondary (0-12) Lawyer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beckie Grushevsky ဂ Henry Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selma Cohen - Wife 7600 Marbury Road Bethesda MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1√2 Burial 2 □ Cremation 3 √2 Removal from State 4 □ Donation 5 □ Other (Specify) King David Mem. Grdns 12/3/06 Falls Church VA 21. Signature of Funeral Ferrico Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Lung Disease Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 2**☑** No 1∐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ₩ Natural 2 Accident Injury To the Hospital Compatible To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and Ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20148 November 27, 2006 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dulinsky 911 Russell Avenue Gaithersburg MD 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

Year)

Registrar's Signature

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2006

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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The contribution of the cause of death of t			ailure List only one cause on	each line.		t enter the mode of dying	g, such as cardia	ac or respiratory ari	est, shock, or heart	Approximate Interval
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25 Was case referred to medical examiner? 1	ecor ne law te has t	E E						autop	sy prior	to completion of cause of
Natural 2 Accident 3 Suicide 4 Homicide 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. State 3 Date filed (Month, Day, Year) Accident 1 Pann Street, Baltimore, MD 21201 1 Natural 2 Accident 3 Suicide 4 Accident 3 Suicide 6 X Could not be determined 2. Accident 3 Suicide 4 Homicide 2. Accident 6 X Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 2. Accident 8 Y Could not be determined 8 Y Could not be determined 8 Y Could not be determined 8 Y Could not be determined 8 Y Could not be determined 8 Y Could not be	an: The					26 Place	of Dooth (Chao	1 ✓ Yes 2		1 .
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Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31 Date filed (Month Day, Year) 1000 32 Registrar's Signature.			Landy Busha	(1, M)		O.C.	M.E.		October 26, 20	006
State 31 Date filed (Month Day, Year) 1003 32 Registrar's Signature						111 Penn Street	Baltimore	MD 21201		
		ite rar	B1 Date filed (Mooth Pay, Year) 21	32 Pegistraris S	ignature.		, = 5.001010,			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Day Dec. 2,2006 12:45 AM Godwin Louise Helen 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Wicomico Salisbury lisbury Rehab + NUrsing Ctr Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) June 14, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 1□ M 2Å F Yrs. 1940 227-48-5114 66 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Salisbury Maryland Wicomico 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country?

Physician

/Medical

Examiner

Funeral

Director

Physician

	Exa	aminer	ı
Division of Vital Records, P.O. Box 68760,	vital or Attending Physician: The lew requires that the death certificate be executed in a short death	ral Director: After this certificate has been signed by the attending physician and rall black the funeral director, page 2 should be detached for use es the buriel-transit	

alD	200 Civic Avenue				2180) 4		USA	A		
ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I,S.	13. Was D	ecedent of	Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Black.	American Ind White, etc.	ian,	
by Funeral D	1 ☐ Never Married	1 ☐ Yes 2 X No If Yes, Give Year or Dates:			s 2DXN			0 "	Black		
eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a.	Decedent's (Give kind o	Usual Occ f work don	upation e during most of wo red)	rking	16b. Kind of Busin	ness/Industry		
Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)			m est			Homen	naker		
Be	17. Fether's Name (First, Middle, Last)			Cook		18. Mother's Na	•	Maiden Sumame)	Sama	lo	
٩	Wilbert		1	Cook	Samp						
	19a. Informant's Name/Reletionship (Ty					et and Number or R)	
	Edward Dildy/husba	20b. F	Place of	Disposition	(Name of	igle RD -	Date	20c. Location - Cit		ate	
	1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		v, ciematory nill M∈	mory	Gdns	12/9/200		n, Mary		
	21. Signature of Tuneral Service License	ee		22. Nam	e and Add	ress of Facility 12	13 Jersey	y Road -	Salisbu	ry, MD	
	Louth	B. Julles	1	JOLL	EY M	EMORIAL	CHAPEL		2	21801	
	23a. Part1. Enter the disease, or combleshock, or heart failure. List only or	ications that/caused the deat ne cause/or each line.	Do n	ot enter the	mode of d	ying, such as cardia	c or respiratory e	rrest,	Interv	oximate val Between t and Death	
1	Immediate Cause (Final disease or condition	Grafin	-	122-4	Dan	Des	000		!	ear-	
_	a. Cutto (or as a consequence of): Due to (or as a consequence of):										
al le	o laronous afters Deplace 15.										
xan	Sequentially list conditions, if any, leading to immediate										
edical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (s		onsequence	of):				-	<u> </u>	
edi	resulting in death) Last	D0 0 0 (0	n as a co	orisequence	017.						
Physician/M		i									
Sici	Part II. Other significant conditions cor	ntributing to death but not res	sulting in	the underly	ng cause	given in Part I.	23b. Did	tobacco use contribute to the cause of death?			
							10	Yes 211No 3	☐ Probably	4 🗆 Unknown	
Completed by								an eutopsy amed?	available	topsy findings prior to on of cause	
nple								20.00	of death?	•	
							1		1 ☐ Yes	2 No	
o Be	25. Was case referred to medical examiner?	Hospital:	1500		1001		ath (Check only o		(0%)		
-	1 Yes 2 No	28a. Date of Injury	28b. T	ime of	28c. In	other: 4 P Nursing I		how injury occurred			
atlon:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	In	ijury M		/ork? □ Yes 2 □ No					
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At h building, etc. (Specif	28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or F City or Town, Stete)						or Rural Rout	e Number,	
Medicai Certifica	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, ation and	death occu Vor investiga	rred at the ation, in my	time, date end place opinion, death occ	e, and due to the urred at the time,	cause(s) and mann date and place, and	er es steted. I due to the c	ause(s)	
Me	29b. Signature and title of certifier	1 11	1		29c. Lice	nse number	(2)	29d. Date signed (I	Month, Dey, Y	(ear)	
)	17/1	11/1/			0	2/34	->	144	106		
	30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (15 1	11/			
	William H. R	200	Civ	ric Ave	Delis	sbury	, MeD:	21804			

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** William Sydney Davis 30, 2006 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Director 414-70-5380 65 May 14, 1941 Tennessee Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The m 27 is marked other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 X Yes 2 □ No Directo Prince George's Maryland Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 740 Audrey Lane 20745 Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Hotel Services 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ဥ Ruby Hurse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4621 E. Capito1 St., SE Wash., DC 20019
of Disposition (Name of Date 20c. Location - City or Town, State Kevin Davis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit, Pages 1
Department of H
Important: If Itel
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 12/11/2006 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 2 wait 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, theart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Clastrointestinal Bleeding /Medical Due to (or as a consequence of): Examiner LIVES Clrrhosis OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner the death certificate be executed Hepatitis burial-tra Due to (or as a consequence of): physician Physician/Medical the as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this funeral . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation Hospitai or Attending Injury 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pietely filled in by the funeral pietely filled in by the funeral pietely filled in by the funeral pietely filled in by the funeral pietely filled in by the funeral pietely filled in by the funeral pietely filled in death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Determined the cause (s) and manner as stated.

Determined the cause (s) and manner as stated. 29a. Certifier Medical (Check only

2

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records.

31. Date filed (Month, Day, Year)
DEC 0 4 2006 State Registrar

one)

29b. Signature and title of centifier

7501 Surrats Road, #307, Clinton, MD Suresh Patel, M.D. 32. Registrar's Signatu

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the

29c. License number

D0064801

29d. Date signed (Month, Day, Year)

30/2006

20735

			For State Registrar	te of Marylan		artment of F		ental Hygier	2006	40455
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Rachael	Dawn	Ι	icken		11 1	8 200	
	Examin		4a. Facility Name (If not institution, give street as	1 1		4b. City, Town, o	r Location of Death		4c. County of Deal	
			5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	ALLE	
	Funeral Director		5. Social Security Number 6. Sex 1		Yrs.	Months Days	Hours Min.	(Month, Day, Yes 01/22/197	ar) Co	thplace (Spate or Foreign ountry) Vland
		. }	Usual Residence of Decedent					01/22/191	U Mai	yland
	nylan ihow	_	10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
	8a-1 s	Director	MD Allegany		Cumb	erland				1 □ Yes 2 🔀 No
	vith th	F	100.01 C - 100.01			10f. Zip Code	24500	10g.	Citizen of What Co	ountry?
	seth v	era	10901 Cedar Kno	LL Lane S Decedent Ever in U.	C 12 1		21502	oifu Vae or No-	USA 14. Race - Ame	arican Indian
30	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23a or 28a-f show eumatic event, the Madical Exabitaermust be notified at	by Funeral	1 Never Married 2 Married 1 If You	lyes 2 M No es, Give ir or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🂢 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc.
Maryland 21215-0036	tural stural		15. Decedent's Education		16a. Dece	dent's Usual Occup	pation	16b.	. Kind of Business	Vhite Undustry
ر 15	nin 72 in nin	Completed	(Specify only highest grade complete)	leted) lege (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of worki	ng		,
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	be filed htal Hygid od other event, II	Be	17. Father's Name (First, Middle, Last)		M:11a			(First, Middle, Maid		. h . w t w
<u>Ş</u>	should and Men a marke umatic	ဥ		Leroy	Mille		Debora			bertson
<u>a</u>			19a. Informant's Name/Relationship (Type, Prir					I Route Number, Cit		
	1 and Health sm 27 ther tr		Deborah J. Miller / market Mil			osition (Name of matory or other place		e, Cumber]	Land, MD. Location - City or	
٥	0 0 = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal				ory 111/20		umberland	
Baltimore,			4 □Donation 5 □Other (Specify) 21. Signatur of F neral Service Licensee	Cum			- 1			1 Home, F.A.
eg Ba	permit. Departimports sny inju		Kohut C. Case	lem	1	104 Decat	ur Street	, Cumberla	•	21502 Approximate
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	ue to (or and consequent	tic	Cance		respiratory arrest,		Interval Between Onset an Death
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	quires that n signed b uld be deta	þ	Part II. Other significant conditions contributin	g to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tobaco	1 -	o the cause of death?
Division of Vital Records,	The law requir sete hes been si page 2 should s	Completed						24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
ita		O	25. Was case referred to medical				26. Place of Death		10 103	2000
>	nyeic nis ce direc	To B	examiner? 1 Tyes No Hospital	1 Unpatient 2	ER/Outpatier	nt 3□ DOA Oth	er: 4 Nursing Ho	ne 5 Residence	6 ☐Other (Spe	cify)
0	Attending Physicien: r death. sctor: After this certifici by the funeral director. I		27. Manner of Death 28a. 1. ■Natural 5 □ Pending	Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at rk?	28d. Describe how in	ijury occurred	
Sio	tendi leath. tor: A the fu	catl	2 Accident investigation				Yes 2 □ No			
\leq	i i i i i	Certification:	4 Homicide determined 28e.	Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ural Route Number,
_	To the Hoepital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physician:	To the best of my kno	wledge, deat	h occurred at the fir	ne, date and place	and due to the cause	e(s) and manner as	s stated
	To the Hospital within 24 hours of To the Funeral completely filled	edical	(Check only 2 Madical Examiner: On	the basis of examinal manner stated.	tion and/or in	vestigation, in my o	ppinion, death occurr	ed at the time, date	and place, and due	e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	11	4-list	29c. Licens	e number	29d. I	Date signed (Mont	h, Day, Year)
)	2		the 1821	THE MOSP	-(1)	131	03178	1/1	118/06	
	500		30. Name and address of person who complete	d cause of death (Item	1 23a) (Type,	Print)		4		
	7		Glenn Bruce Vanleve	e, MIMPA	1, 6	00 Sets-	Auc Con	- Gerland	MD	
. 20.	Sta Regi sti		31. Date filed (Month Pay 2°0 2006	d cause of death (Item 32 Registrar's Signa	ture					

			For State Registrer		State of	Marylar		artmen rtificat			nd Me		gienę leg. Né	71116	4 (1456
	Physicial	20	Decedent's Name (First,	Middle, Last,)						2	. Date of Dea Month	ith Da	y Year	3. Tir	me of Death
	Physici /Medio		Ronald Rich	ard Do	man							ecember		2006		:15 PM
1	Examir	ner	4a. Facility Name (If not inst	itution, give	street and numb	oer)		4b. City,		Location of	f Death		4c	. County of Dea	ith	
			4224 Norbeck	Road 6. Se	7	Ann /In wrs	last birthday)	If Under	Rocky	/ille	24 Hrs. p	. Date of Birth		Montgo		tate or Foreign
н	Funeral Director		5. Social Security Number		±M 2□F		Yrs.	Months	Days	Hours	Min.	(Month, Day	, Year)	.		tate or Foreign
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	yland		10a. State 10b. C	ounty		10c. Ci	ty, Town or Lo	cation							10d. Insi	de City Limits
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	or 28	Director	10e. Street and Number					10f. Zip		000E2			10g. Ci	izen of Whal C	ountry?	
	s within 72 hours after death with the Maryland Jene r then "netural", or Iteme 23a or 28a-f ehow the Mauinal Examinett- unt be ricitified at	Ta I	4224 Norbec	K ROAG						20853				USA		
	or Items	Funeral	11. Marital Status		12. Was Deced	es?	I.S. 13.	Was Dece If Yes, spe	dent of His orfy Cuban	panic Orig , Mexican	in? (Speci , Puerto Ri	fy Yes or No- can, etc.)		14. Race - Am Black, Whi		an,
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	be filed ntal Hygid of other event, I	Bec	17. Father's Name (First, M	iddle, Last)	- M		7200			18. Mother	r's Name (First, Middle,	Maider	Sumame)	•	
Jai	Vents Vents rked	To E	Joseph L. Doma	n						Eug	enia R	. Synowk	a			
Maryland	as 1 and 2 should b of Heelth and Ment litem 27 ie marked rother treumatic e		19a. Informant's Name/Rel	, , ,			1		,				. ,	or Town, State,	Zip Code)	
	1 and 1 Heelth em 27		Catherine M. M	cCarthy	/ Wife					Rock		Marylar				
Baltimore,	H ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremi	ation 3 □F	Removal from St		Place of Dispo cemetery, crea	matory or o	me or other place) De	Dai cember	_	20c. L	ocation - City or	r Iown, Sta	ite
Ë	mit. Pages partment of loortant: If its injury or o		4 ☐ Donation 5 ☐ Otl	ner (Specify)		Gat	e of Hea			7	2006			ver Spri	ng, Ma	ryland
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P.O. Box 68	that the death certifica ed by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 yes 2 no	?	4□Pregnar 9□Unknov	th 2 ☐ Feta ntattime of o vn	aldeath 3[death 5[⊒Ectopic p ⊒ Other (s _i	pecify)	n in Part I.		23e. Did to		23d. Date of de Month use contribute t	Day	Year e of death?
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Vital		0	25. Was case referred to m	edical			· · · · · · · · · · · · · · · · · · ·			26. Place	of Death (1 □ Yes Check only o		, , , ,	2011	
<u> </u>	S S D	08	examiner? 1 ☐ Yes 2 ☑ No	Ī	Hospital: 1 🗌 Inj	patient 2	ER/Outpatie	nt_3 🗆 D0	Othe	_				6 ☐Other (Spe	ecity)	
٥٥		n: T	27. Manner of Death	londing	28a. Date of	Injury , Day Year)	28b. Time o	of :	28c. Injury Work	at	28	d. Describe h	ow inju	ry occurred		
Ö	Attending r death. ector: After by the fune	atic	2 Accident	Pending				М		es 2 🗆 t	No					
Division	tal or Attendi s after death. I Director: A ed in by the fu	Certification:		Could not be letermined	28e. Place of building	of Injury - At h g, etc. (Speci	ome, farm, st	reet, factor	y, office		28	f. Location (S City or Tow	itreet ai m, Stat	nd Number or R e)	lural Route	Number,
	Hospit 4 hour Funer ely fills	Medical (sicien: To the biner: On the bas	sis of examina										use(s)
	To the within 2. To the I complet	Me	29b. Signature and title of	ertifier	1)	7111	Λ	29	c. License					te signed (Mon		ear)
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	571	1	30. Name and address of p	4 /												
_			Nakul Goyal,		01 Intern			#211,	Silve	r Spri	ng, MD	20906				
	St Regist	ate rar	31. Date filed (Month, Day,	Year) = 4 2	32 Ae	gistrar's Sign	ature	and I	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Sharon Lynn Dewease 2006 Dec 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Hospital Washington *Hagerstown* If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeal) 957 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 1 F Yrs 49 217-70-4259 August 15, Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10116 Easterday Crt. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Agent <u>Marketing</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Raymond Magruder, Sr. Patricia Deatley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Husband) Carl E. Dewease 10116 Easterday Crt. Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5, 2006 Smithsburg, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J.L. Davis Funeral Home Mol4/4 | 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemovi disease or condition resulting in death) Due to (or as a consequence of): lons Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? th but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed: 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Injury at Work?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or

"natural", or items 23a

the Medical

traumatic event,

Department of Health a Important: If item 27 Is any Injury or other trainonce.

and 2 should be filed within 72 hours after death with teath and Mental Hygiene. m 27 Is marked other than "natural", or items 23a or:

Baltimore, Maryland 21215-0036

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P.O. Box 68760.

Records,

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TO ME

After this e Hospital or Attending P 24 hours after death. e Funeral Director: After t the

9 ☐ Unknown	9□Unknow
t II. Other significant condition	ons contributing to deat
Keyperten	•

25. Was case referred to medical examiner? 1 ☐ Yes 2 → No

> 1 Natural 2 Accident 5 Pending investigation 3 ☐ Suicide 4 Homicide

(Check only one)

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of MUSICIAN

29d. Date signed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print) 110 Redical

and manner stated.

31. Date filed (Month, Day, DEC 1 9 2006 gistrar's Signature

To the Hospital within 24 hours at To the Funeral D

DHMH 17 Rev 1/2001

Registrar

		•	For State Registrar	State of	Marylan		artmen			and M		gien Reg. N	211116	40460
			1. Decedent's Name (First, Middle, La	ist)							2. Date of De	ath		3. Time of Death
П	Physicia /Medic		MILDRED MAXINE E	ASTERLI	1						NOVEMB		30, 2006	10:10A M
	Examin		4a. Facility Name (If not institution, gir	re street and num	iber)		4b. City,	Town, or	Location of	of Death		40	c. County of Death	
			3508 PARKWAY TER				W.11=-		UITL				PRINCE G	
n	Funeral		,	Sex 1□M XXF	7. Age (In yrs. 5	last birthday) 2 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da OCT • 2	rth av <i>Year</i> O	9. Birthp Coyr 1954 WASH	place (State or Foreign office), DC
	Director		579 74 8872 Usual Residence of Decedent								-001. 2	,	1994 WASII	INGTON, DC
	ylanc		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	ith the Marylan or 28e-1 show	ctor	MD PRINCE	GEORGES	S	UITLAN	D							1XXYes 2 □ No
	or 28	Oire	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What Cour	ntry?
	s 23a	Funeral Director	3508 PARKWAY TER	T					0746				ITED STAT	
	items	nne	11. Marital Status XX Never Married 2□ Married	12. Was Dece Armed For 1 ☐ Yes ∑	ces?	.S. 13.	Was Deced	lent of Hi offy Cuba	spanic Ori n, Mexican	gin? (Spe n, Puerto	cify Yes or No Rican, etc.))- 	14. Race - Americ Black, White,	
39	urs aff	þ	3 Widowed 4 Divorced	If Yes, Give	9		1 ☐ Yes 2	∑ No	Specify:				Specify: WHI	TE
Ö	within 72 hours after death with the Maryland ene. then *natural', or items 23e or 28e-1 show the Macical Exc. altret clust be motified at	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usua	I Occupa	tion	4 a4add		16b. l	Kind of Business/Inc	dustry
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Maryland	s be fi	Be	17. Father's Name (First, Middle, Last)							(First, Middle	, маіде	in Surname)	
Ž	should I ind Men is marke umatic	J.	OBIE EASTERLIN 19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	na Address	(Street a			OWENS	er City	or Town, State, Zip	Code)
	and 2 s balth ar n 27 Is ler treu		APRIL HYSON-CLAR		HTER		NDY L					-	, MD 2074	
Ē,	es 1 ar of Hea of Item of Item		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	1		ate		Location - City or To	
altimore,	Pages nent of ant: If Its ary or o		XXBurial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci		iate	HINGTO	-			4. 12	/9/06		SUITLAND	, MD
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heatth and Mental Hygiene. Importent: If Item 27 Is marked other than "natural; or items 23a or 28e-1 show any injury or other treumatic event, Ite Medical Examitment in the Instituted all once.		21. Signature of Funeral Service Lice	nsee Class	0.00	0.747	Name and	ALL'	S FUN	ÍERAL	HOME	OF N	MARYLAND,	ĮŅC.
			23a. Part1 Enter the disease, or con	plications that ca	used the deat		4308 er the mode						D, MD 207	Approximate
	Physician ₁		shock or heart failure. List only Immediate Cause (Finaf			T DANG	DEAG							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		NOMA O		REAS							
	Examiner		Sequentially list conditions	b. DIABE	ETES ME	LLITUS								
	pa tis	iner	Sequentially list conditions, any earling transcript cause. Enter Underlying Cause (Disease or injury		or as a consuq	,								
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Box	eath certifica attending pl for use as t	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		Ectopic pro	eduancy					23d. Date of delive	*
<u>.</u>	e deal	sicis	in the past 12 months?		ant at time of d		Other (sp						Month	Day Year
P. O.	res that the de signed by the a be detached f		9 ☐ Unknown Part II. Other significant conditions	contributing to de	ath but not rec	ultion in the u	adarkijas ar		o in Bort I		23a Did t	obacco	use contribute to th	ne cause of death?
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ta		BeC	25. Was case referred to medical						26. Place	of Death	(Check only of	2XXN∈ one)	0 10163	2010
<u>_</u>	Physicien: r this certificar ral director, i	To	examiner? 1 Tes 2XNo	Hospital: 1 🗆 Ir	patient 2	ER/Outpatier	nt 3∐ DO	A Othe	r. 4 □ Nu	rsing Hor	ne XXResi	dence	6 □Other (Specify	1)
D C	or Attending Phatter death. Director: After thin by the funeral		27. Manner of Death 1XXNatural 5 ☐ Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time of Injury		8c. Injury Work	at ?	2	28d. Describe			
S	Attending it death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	99 Phon	of Injury - At he	ome form str	M		′es 2 🗆 I	-	on Location /	Stroot	and Number or Rura	I Pouto Alumbos
<u>≥</u>	el or Attendation after death	Certification:	4 Homicide determined	buildin	g, etc. (Specif	y)	eer, ractory	, onice		· ·	City or To			i noule ivalibel,
	To the Hospitel within 24 hours a within 24 hours a completely filled	edicai C	29a. Certifier (Check only one) XX Certifying P. 2 Medical Exa	hysician: To the miner: On the ba and mann	sis of examina	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	e, date an inion, deal	d place, a	and due to the ed at the time,	cause(s date an	s) and manner as st nd place, and due to	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier				29c	. License	number			29d. Da	ate signed (Month, i	Day, Year)
	- > - 0		> Seacon	KNO	,			D55	314			DEC	CEMBER 03	, 2006
2	2		30. Name and address of person who		of death (Iten	n 23a) (Type,	Print)							
			SYLVESTER OKONKW			2 OXON		RD.	#507	7 C	XON HI	LL,	MD 20745	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4 2006	De eu	egistrar's Signa	Speek	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Edward مان 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cumberlana Braddock Campus Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Min. Maryland 216-30-1683 16-Feb-34 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Allegany Frostburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10935 Parkersburg Road, N.W. 21532-U.S.A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No Wes, Give .1 45.3 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) fibers manufacturer unknown 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mildred Rice Harry R. Edwards 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry P. Edwards, Jr. 21532 Maryland 10935 Parkersburg Road Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22-Nov-06 Cumberland Maryland Cumberland Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 0 Immediate Cause (Final 111

Physician /Medical Examiner

Important: If eny Injury or once.

Physician

Examiner

Funeral

Director

ehow.

Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hyglene.
The strick them to 72 fe marked other than "natural", or itema 23a or 28a-1 eho ury or other treumatic event, the Medical Exampla from the modified at ury or other treumatic event, the Medical Exampla from the modified at

Baltimore, Maryland 21215-0036

death with the Maryland

/Medical

10a. State

Director

Funeral

Be Completed by

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inding physicien and use as the burial-transit signed by the attending I be detached for use as s certificate has I lirector, page 2 s within 24 hours after death To the Funeral Director: , completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	Due to (or as a consequ		ctim						
Physician/Medicai Examiner	Fequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic p			23d. Date of delivery Month D	ay Year			
	Part II. Other significant conditions con Chrmic obstru	use contribute to the	cause of death?							
Completed by	Hypertension,	Habestos	15		24a. Was an autopsy performed? 1 Yes 2 N	prior to comp death?	y findings available pletion of cause of No			
Be	25. Was case referred to medical			26. Place of De	ath (Check only one)					
0	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 🗆	ER/Outpatient 3 Do	OA Other: 4 Nursing H	lome 5 Residence	6 ☐Other (Specify)				
ation;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred				
Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factor	y, office	28f. Location (Street a City or Town, Sta	nd Number or Rural f e)	Route Number.			
ical		sician: To the best of my knowner: On the basis of examinat								

State Registrar 29b. Signature and title of certifier

ompleted cause of death (Item 23a) (Type, Print)

29c. License number

D005729

29d Pate signed (Month, Day, Year)

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			1- For State of Ma	-	artment of Health and rtificate of Death		ene 006	40462
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici		JAMES	EDG	EHILL	Month NOVEMBE	R 30, 2006	3:30A M
-	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea		4c. County of Death	3.5011
	LAGITIT	7	BRADFORD OAKS NURSING & RE	HΔR	CLINTON		PRINCE	CEORCES
	Funeral			(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs			
	Director		155 03 1214 XXM 2□F	83 Yrs.	Months Days Hours Min		Year) Court	lace (State or Foreign try) YORK
			Usual Residence of Decedent	03		JULI 04,	1 JZJ NEW	TORK
	/land		10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits
	Mar 1 st	ţō	MD PRINCE GEORGES	FORT WA	SHINGTON			XXYes 2 ☐ No
	the	rec	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Coun	try?
	3a o	Funeral Director	310 BONHILL DRIVE		20744		UNITED STA	rfc
	ns 2:	era	11. Marital Status 12. Was Decedent E	ver in U.S. 13.1	==	Specify Yes or No-	14. Race - Americ	
	iter iter	Ë	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Yes		Was Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Puer	rto Rican, etc.)	Black, White,	
21215-0036	Irs a	β	3 ☐ Widowed XXDivorced If Yes, Give Year or Dates:		1 ☐ Yes 2/CXNo Specify:		Specify: BLA	CK
ş	be filed within 72 hours after death with the Maryland tal Hygiene. id other then "natural", or items 23a or 28e-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's Education	16a. Decer	dent's Usual Occupation	1	6b. Kind of Business/Ind	lustry
15	- 100	plet	(Specify only highest grade completed)	(Give	kind of work done during most of wo DO NOT use retired)	orking		,
7	filed within Hygiene. Ither than "	E	Elementary/Secondary (0-12) College (1-4or 5-8TH	BUST	NESSMAN		PRIVATE	
	filed Hyg other		17. Father's Name (First, Middle, Last)			me (First, Middle, M		
a	d be ental	o Be	JOHN WESLEY EDGEHILL		WINTE	RED CLARA	DOTTON	
\geq	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, Ing M	²	19a. Informant's Name/Relationship (Type, Print)	19h Mailir	ng Address (Street and Number or R			Code
Maryland							NGTON, MD 20	
رة	is 1 and of Health item 27 other to		20a, Method of Disposition	20b, Place of Dispo	sition (Name of		Oc. Location - City or To	
و	00		XXBurial 2 Cremation 3 Removal from State	cemetery, cren	natory or other place)			
Baltimore,	rtmer rtent njury		' 4 □ Donation 5 □ Other (Specify) 21. Signatore of Fune al Service UsenSe		CITY CEMETERY 12		PLEASANTV	
Ba	permit. Pag Department Importent: I any injury o		21. Signated of Fundamental Solves Charleton		MARSHALL SFEUNE 4308 SUITLAND RO	RAL HOME (DAD SUITI	OF MARYLAND LAND, MD 20	INC.
			23a. Part1/ Enter the disease, or complications that caused shock, if heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dying, such as cardia	c or respiratory arre	st,	Approximate Interval Between
	Pnysician		Immediate Jause (Final disease of Condition ALZHEIM)	ER'S DISEA	SE			Onset and Death
	/Medical		resulting in death)	a consequence of):	D11			
	Examiner		Sequentially list conditions b.					
	p	Examiner	cause. Enter Underlying	a consequence of):				
	acute ind trans	am	Cause (Cristass or injury that initiated events resulting in death) Last C.					
/60,	ate be executed hysician and the burial-transit		Due to (or as a	a consequence of):				
876	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lical	d					
9	eath certifica attending pt for use as t	Physician/Med	IF FEMALE:					
Box	ith ce tend or usi	an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	,
	e dea he at hed fo	sici	1 Yes 2 No 4 Pregnant at	time of death 5	Other (specify)		Month	Day Year
J.	at the de i by the a stached	Phy	9 Unknown					
Ś	res that igned b be det	by	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause given in Part I.		acco use contribute to th	
ecords,	w requir been si should	led				1 🗆 Yes	s XIX No 3 ☐ Prob	ably 4 Dunknown
ပ္ထ	aw nas be	pie				24a. Was an autopsy		esy findings available
T.	nysician: The law his certificate has l I director, page 2 s	Completed				perform	ed? death?	2 No
Vital		Be C	25. Was case referred to medical		26. Place of De	ath (Check only one		
	ysic is ce direc	0	examiner? 1 ☐ Yes ※XXNo Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	t 3 DOA Other: XX Nursing I	Home 5 Residen	nce 6 Other (Specify)
o	ding Ph. After thi funeral	n: T	27. Manner of Death 1X XNatural 5 Dending (Month, Day	y 28b. Time of Injury		28d. Describe hov		
0	kttendin death. ctor: Afi y the fur	atio	1XXNatural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	, our, injury	M 1 ☐ Yes 2 ☐ No			
DIVISION	or Attending Physician: ifter death. Director: After this certifici in by the funeral director,	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ry - At home, farm, stre	eet, factory, office	28f. Location (Stre	set and Number or Rura.	Route Number,
5	itel or rrs aft rel Di	Certification:						
	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of and manner state	examination and/or inv	n occurred at the time, date and place restigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as state and place, and due to	ated. the cause(s)
	To th withir To th Somp	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month, L	Day, Year)
			Well Volen	M	D38206	1	NOVEMBER 30	2006
	E		30. Name and address of person who completed cause of de	path (Item 23a) (Type,	Print)			
	9		WILLIAM T. TANNER, M.D.	11701	LIVINGSTON RD.	FORT WASH	INGTON, MD	20744
	Sta		31. Date filed (Month, Day, Year) 2. Registra	r's Signature	d)			
	Registr	ar	DEC 0 4 2006 Franker	10. 19				

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of Heartificate of De	aith and Me eath	ental Hygie		40463
			Decedent's Name (First, Middle, Last)				2	2. Date of Death		3. Time of Death
П	Physici /Medio		Adith Melvin	ia Frazi	er]	Month December	Day Year 2006	1:37 p. M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death		4c. County of Dea	
			Chesapeake Wood			Cambr			Dorche	
П	Funeral		5. Social Security Number 6. Sex	7. Age M 2[3 [F	(In yrs. last birthday)		Hours Min.	Month, Day, Ye		rthplace (State or Foreign ountry)
	Director		215-20-4780 Usual Residence of Decedent		86		A	oril 11,	1920 Ma	aryland
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Ç	e-f sl	ctor	MD Dorches	ter		Madi	son			1 ☐ Yes 2 X No
2	or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
3	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23e or 28e-f show ont. The Medical Examiner must be mulified at	ral	1227 Old Madison			216			USA	
6	er de	Funeral		12. Was Decedent E Armed Forces?		Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:		1 ☐ Yes 212 No S	Specify:		Specify: V	white
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupatio	n	166	. Kind of Business	
215	thin 7 9. Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	kind of work done durii DO NOT use retired)	ng most of working			
	ed wii ygien yer th	Con	6		<u> </u>	line wor	ker	ga	arment mf	g.
nd	be fill d oth	Be	17. Father's Name (First, Middle, Last)			18	. Mother's Name (den Sumame)	
3	d Mer narke	오	Wilbur Jarrett				Leila 1			
Ma	d 2 sl th an 7 ls r treur		19a. Informant's Name/Relationship (Ty) Phyllis James	•		ng Address (Street and				
ð,	s 1 and 2. of Health ar item 27 is		20a. Method of Disposition	daughte	20b. Place of Dispo	Pennsylvan sition (Name of	nia Ave.		1, MD 21 Location - City or	648
ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other than "naturel", or Items 23e or 28e-f show any injury or other treumetic event. It s Medical Examiner must be notified at once.		1 ☐ Surial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place)	 - 10/5/6		•	
Baltimore, Maryland	artm. orter injur		21. Signature of Funeral Service License	90	DOLCHESCE	r Mem. Par ! Name and Address o	K 12/5/C	De Funor	ambrid	D A
ä	Depar Impor any tr		Brik. Br		V	700 Locust	St. Can	as runei bridae.	MD 2161	
	*		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	. 4	norrhacie	Strok				Onset and Death
	/Medical		resulting in death)		a consequenc (o):	.,,,,				
	Examiner	_	Sequentially list conditions, b		11765					
	led Isit	nine	if any, leading to immediate Cause (Disease or injury	Due to (or as a	a consequence of):					
_	al-tra	Examiner	that initiated events cresulting in death) Last	Due to (or as a	a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicat F								
9	tificat ng phy as th	ledi								
Вох	eath certific attending p	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnancy			23d. Date of de	
	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown		Other (specify)			Month	Day Year
P.O.	that the de ed by the a detached t	Phy	Part II. Other significant conditions con	tributing to double bu	t ant manufalme in the co		- D. Al	22a Did tabasa		o the cause of death?
ds,	ires tha signed d be det	by	Takin. Other signmeant conditions con	thouling to death bu	ic not resulting in the di	idenying cause given it	I Fall I.			robably 4 Unknown
Š	w require been si should t	etec								
Records,	has ge 2	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
VItal			25. Was case referred to medical					1 Yes 2 ₽		2046
	ysicie is cert direct	To Be	examiner?	ospital:	nt 2 ER/Outpatien	0	3. Place of Death (6 4 Aursing Home		e Cother (Co	
Division of	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day	y 28b. Time of			d. Describe how in		icity)
0	Attending P death. ctor: After y the funera	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		2 🗆 No			
<u> </u>	r Attencer death	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm, str. (Specify)	eet, factory, office	281	Location (Street City or Town, St		ural Route Number,
≧	Itel o	Cer								
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Madical Examin	ar: On the basis of	examination and/or inv	occurred at the time, ovestigation, in my opinio	date and place, and on, death occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stat	leg.	29c. License nu			Date signed (Mont	
	F 3 F 8) du mi	7 N	10		924		2 - 4- 06	'
			30. Name and address of person who co	moveted cause of de	ath (Item 23a) (Type	0 1	· ·		7- 00	-
			NOMAN THANKY		AURURA	ST CAMI	RIDGE	MD	21613	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					
	Registr	ar	DEC 0 5	(005	us the	Sporte				

Physician /Medical Examiner

Funeral Director

with the Maryland or 28e-f show the Medical Examiner must be notified at Director Iteme 23a death Funeral filed within 72 hours after "naturel", or other then permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If Item 27 is marked other tt any injury or other traumatic event, III.8 Be

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> use as the burial-transit the ettending physicien and ó been signed by has this certificete completely filled in by the funeral After death. Director

The law requires that the death certificate be executed

or Attending Physician:

hours after 24 hours

within 2 To the

Division of Vital Records, P.O. Box 68760

2. Date of Death 3. Time of Death Blanche French 5:40 p.M November 29 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Dorchester Mallard Bay Care Center Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 8, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 M F Yrs. Maryland 89 214-07-7591 Usual Residence of Decedent 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ¥Yes 2 ☐ No Cambridge Dorchester MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 USA 520 Glenburn Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: white Specify: δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) garment mfg. secretary 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Emma Keene Edward R. Gore 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Algonquin Road, Cambridge, MD <u>Margaret Moosegian</u> p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park | 12/4/06 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Brik. Bu 700 Locust St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Progressio MICO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of C. Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à OS teoporosis 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2500 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one| Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Norsing Home 5 Residence 6 Other (Specify) ٩ 1 Tes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending t ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number techelle mes 026389

State Registrar

Michael 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

302 Collins Hurlock

nd address of person who completed cause of death (Item 23a) (Type, Print)

FACILLEN MA

06-09232 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Arthur Albert Friend, Jr. 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Time of Deat Month Day December 4, 2006 Medical Examiner Arthur Albert Friend, Jr. 1615 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 7521 Riverdale Road #1964 New Carroliton Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Months Days Hours March23,1966 oreignaryland 40 212-98-5181 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No Maryland Prince George's Beltsville with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20705 4711 Lincoln Avenue United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces' White etc 2 X No Yes Yes, Give Year Yes 2 X No specify: Specify White Widowed Divorced <u>۾</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 12 never worked none Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur A. Friend, Sr. Linda H. Cumberland Be traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Arthur A. Friend, Sr.-father 4711 Lincoln Avenue Beltsville, Maryland 20705 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Burial 2 XCremation 3 crematory or other place) njury or other Removal from State Metropolitan Crematory12/5/2006 Alexandria, Virginia Other Specify: Donation 5 Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licensee and Marvland20705 23a. Part I. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on /Medical Death Diabetic ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and I be detached for use as the burial - transi Physician/Medical X UNPENDED AMENDED #23a, 27, perME, g863, 1/2/07 TT To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

within 24 hours after death.

completely little in by the inneral director, page 2 should be detached for use as the burist completely little in by the inneral director, page 2 should be detached for use as the burist. Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was ar autopsy prior to completion of cause of performed? death? Yes No Yes 2 ~ 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 1/2001

OCME 2006

Medical

State

29b. Signature and title of certifier

Ling Li, MD

31. Date filed (Month DEC

and manner stated

mis

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2006

Assistant Medical Examiner

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 5, 2006

			1 - For State Ragistrar	State of M	Marylan		artment tificate				ental H	ygiene Reg. No.	2006	40466	
	Physici	an	1. Decedent's Name (First, Middle	irst, Middle, Last)							2. Date of I	Day		3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution	give street and number	er)		4b. City, 1	Town or	Location	of Death	12	08	2006 County of Deat		
	Exami	lei				redical				none		40.	NIA	.,	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign											hplace (State or Foreign	
	d within 72 hours after death with the Maryland diene. Titina "natural", or Iteme 23s or 28s-f show the Maclical Examination will be notified at the Maclical Examination of the Maclical Examination		162-32-4209	1 ⊠ M 2□F	66	Yrs.	WOTTERS	Days	riodis	Will I.	04-	21-19	140 Per	nsy Ivania	
			Usual residence of Decedent									10d. Inside City Limits			
		to										1 ☐ Yes 2 No			
		Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								untry?				
		rai	126 Maple Dr. 19946 u								SA				
		Funeral	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13.	Vas Decede Yes, speci	ent of His fy Cubar	panic Ori , Mexican	gin? (Spec n, Puerto P	ecify Yes or No- Rican, etc.)		 Race - Ame Black, White 		
936		by F	1 ☐ Never Married 2 € Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔼 No Sp			Specify:			Specify: white		
Š		ted	15. Deceden		Education rade completed) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			6 - 6 · · · - ml · i-m		16b. Kir	Kind of Business/Industry		
21		To Be Completed	Elementary/Secondary (0-12)									0			
2	7 7 L M		17. Father's Name (First, Middle,	(act)		Airc	ratt			ian i	(First, Midd	Civ		rvice	
Maryland 21215-0036	s 1 end 2 should be filed f Health and Mental Hyg frem 27 Is marked otha other traumatic event,		_	Fair, Sr	•						GI		,		
ary			19a. Informant's Name/Relations		_	19b. Mailin	g Address	(Street a					Town, State, Z	ip Code)	
			Carol J. Fair	- wit		126			Dr	, F	rede	rice	. De	19946	
ore	t of H t of H if iter		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 ☐Removal from Sta	e c	lace of Dispo- emetery, cren	natory or oth	her place)		ate		ation - City or		
Baltimore,	t Partmen		4 □ Donation 5 □ Other (S		Re	st Ha					5-2006	Ho	mover,	FA	
Ba	permit. Pages: Department of the Important: If its eny Injury or of once.) } }	21. Signature of Funeral Service Sulliva C	restur		To		-1	Fune	eral			Dove	r. De	
	Physician and physician and physician and physician and the private ithe private in the private		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death line.	n. Do not ente	er the mode	of dying	, such as	cardiac or	respiratory	arrest,		Approximate Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death)	a. Se	Due to (or as a consequence of):									1 day	
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or a										- day	
		Examiner	that initiated events												
8760,	be execian a		resulting in death) Last	Due to (or a	is a consequ	uence of):									
387	death certificate be executed e ettending physician and id for use as the burial-transit	Physician/Medical		d											
Box 6	eath certific ettending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year			
ŏ.	death e ette	Iciai	in the past 12 months?	4 ☐ Pregnant											
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Ö	or Attending Physician ifter death. Director: After this certifi in by the funeral director	etec								1 Yes 2 No 3 Probably 4 Unknown					
æ		Completed										24a. Was an autopsy findings available prior to completion of cause of death?			
ta		Be C	25. Was case referred to medical	performed? death? 1 Yes 2 No 1 Yes 2										2 No	
⋛		ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 12 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
0 0			27. Manner of Death 1 Natural 5 ☐ Pending								cribe how injury occurred				
sio		cati	2 Accident investig	ation	bo						COLL Leading (Charles of N.				
Division of Vital Record		Certification;	4 Homicide determi	ned 286. Place of the building, i	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Stree City or Town, Street)							(Street and own, State)	t and Number or Rural Route Number. tate)		
	To the Hospital or within 24 hours efter To the Funerel Dir completely filled in	edicai (
	Vithir To th comp	Me	29b. Signature and title of certifier 29c. License number								29d. Date signed (Month, Day, Year)				
)) K. E	Jallyher.	m. I).		145	47			12/	8/06		
		1	30. Name and address of person v	_		^	Print)		•				•		
	Sta	te.	31. Date filed (Month, Day, Year)	mD 32. Regis	trar's Signal	Green	< 5tm	eut	150	ムかり	none,	mo	212	01	
	Registra		DEC 1 7 200	6	15	25°									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month GREENE 2:30 PM /Medical November 30 2006 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Haryland Medical Center
5. Social Security Number 6. Sex 7. Age (In yi Baltimore If Under 24 Hrs. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 202 F Months Days Hours Min 215-38-0407 Usual Residence of Decedent Yrs. 149.231940 Director 66 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director STON 10e. Street and Number 10g. Citizen of What Country? filed within 72 hours after death with 21601 ammon Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SS: Stant Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health end Mental H tant: If item 27 Is marked out jury or other traumatic even Be 2 William Greene 4nnabel1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health er
Important: If item 27 Is
any injury or other trau Road Easton, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Queen Esther Cemetery 06 Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, P. A. Herry Fune Rul Home, P. A. 21. Signature of Funeral Service Licensee 510 washington St. Cambridge, 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatitis Ne anotizing /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed res 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rachel Greenberg M.D. 17415 2006 November

Registrar
DHMH 17 Rev 1/2001

State

Rachel

31. Date filed (Month,

225. Greena St. Baltimone, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Greenberg

State of Maryland / Department of Health and Mental Hygiene 40468 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Charles C. Gunn December 3, 2006 10:38 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8110 Runnymeade Drive Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore Country) | October 31, 1921 | Mississippi 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** ₩ 2 □ F 426-18-5874 85 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic avent, the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8110 Runnymeade Drive 21702 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. Affiled Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify: Completed by 3 TWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ground operations manager **Airlines** f Health and Mental Hygie Itam 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I Christopher Clayborn Gunn Lorena Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Wiley - daughter P. O. Box 225, Lagunitas, California 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Frederick Crematory Dec.06,2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceriese 22. Name and Address of Facility Stauffer Funeral Home aron amelle (Med 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 should be 3 Probably 4 Donknown Completed 1 Yes 2 No Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 hes autopsy performed certificate 2 No 2□ No 1□ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Alter Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No м within 24 hours after death.

7 to the Funeral Director; A completely filled in by the fr 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Digistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2.0.0.6

			For State Registrar	State of Mary		rtificate of l			eg. No.	0 4046
7	Physici		1. Decedent's Name (First, Middle, Last) Chery1 E. Gill	lespie				2. Date of Dear Month Nov.	Day Year 30 2006	3. Time of Death 2:40 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of Dea	
*	Funeral Director		Prince George 5. Social Security Number 6. Sex 1 1 N	7. Age (In	yrs. last birthday) 58 Yrs.		Chever1y If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 29	Year) 9. Bii	Georges' thplace (State or Foreign ash., DC
	pu .		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo					
	e Maryla la-f shov	ctor	Maryland Prince Ge		. City, rown or La	Mitchel	lville			10d. Inside City Limits 1 X Yes 2 No
	ih th or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a	ra	11220 Lake Overlo	ok Place			20721		United	States
900	be filed within 72 hours after death with the Maryland hal Hygiene. ed other then "natural", or Itams 23e or 28e-f show event, the Mysteral Exartinal must be notified at	by Funeral	11. Marital Status 12 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	. Was Decedent Ever Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ANo		ecity Yes or No- Rican, etc.)	14. Race - Am- Black, Whi Specify:	
21215-0036	within 72 ha ene. then "natu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Business	/Industry
12	e filed within al Hygiene. I other then vent, the Man		12th			Office				vate
and	be fill	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		,	
ž	d Mer marke	P	Norbert A. I		tob Marili				L. Procto	
Maryland	d 2 s th an th an t7 ls i		19a. Informant's Name/Relationship (Type						, City or Town, State,	
	Heal Heal tam		Michele T. Polla 20a. Method of Disposition	ard/Daugnte	b. Place of Dispo	sition (Name of			LLV1LLE MI 20c. Location - City or	
E O	Page ent of nt: If i		1 ☐ Burial 2 【XCremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		matory or other plac Cremator		2006	Clinto	n. MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other traumatic er once.		21. Signature of Funeral Service Licensee	ti m t		2. Name and Addres	ss of Facility	Stewart	Funeral Howash., Do	ome
			23a. Part1. Anter the disease, or complica	tions that caused the	leath. Do not ent					Approximate
W. Art	Physician /Medical		shock or heart failure. List only one Immediate Gause (Final disease or condition resulting in death)	META STA	TIC y	BREAST	4			Interval Between Onset and Death
	Examiner	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	PNEUMOI Due to (or as a con						
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	SEPS15						
68760,	tificate be executed ig physicien and as the burial-transit		d.	Due to (or as a con	sequence of):					
	= 0.4	Aedicai	IS SECURIT							
.O. Box	res that the death cer igned by the attendir be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Ω_	The law requires that the ste has been signed by thoage 2 should be detached.	þ	Part II. Other significant conditions contri DIABETES	buting to death but not	resulting in the u	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?
Vital Records,	: The law require cate has been sig , page 2 should b	Completed	SEIZURES					24a. Was ar		utopsy findings available completion of cause of
=		Con						perform	ned? death?	2□ No
Vita	ysicisn: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h Check only on	9)	
o	90 W ==	5 T	1 ☐ Yes 2 X No		2 X ER/Outpatier		4 Nursing Ho		nce 6 ☐Other (Spe	cify)
no	Jing After fune	tion	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Work	rat ⟨? Yes 2 □No	28d. Describe ho	w injury occurred	
Division	al or Attending after death. I Director: After d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str ecify)			28f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	ian: To the best of my r: On the basis of exan and manner stated.	knowledge, death ination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	tuse(s) and manner as ate and place, and due	s stated. to the cause(s)
	To ti To ti comp	Ž	29b. Signature and title of certifier			29c. License	number	25	d. Date signed (Mont	h, Day, Year)
) (·) ×			mi	0581	82	11/30/00	e e
R	(3)		30. Name and address of person who comp	pleted cause of death (Item 23a) (Туре, 300/ -	Print) HOSFITAL	DR	CHEV	ERLY MD	20785
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4 2006	32. Registrar's S		į,			1	

State of Maryland / Department of Health and Mental Hygiene UU5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 30, 2006 **Physician** ELWOOD GRAHAM, SR. 4:15 P M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 29 Sunbrook Lane Hagerstown Washington County 8. Date of Birth (Month, Day, Year)
July 22, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 406-12-9963 1921 Director 85 Ohio Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10a. State 10d. Inside City Limits 28a-f show or than "natural; or items 23a or 28a-f show the Medical Examinar must be notified at 1 Ves 2 □ No Directo Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Sunbrook Lane 21742 U.S.A. Pages 1 and 2 should be filed within 72 hours after deeth Funera 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wage Board Manager Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I John E. Graham Anna Ruth McKinnev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Woody Graham / Son 26 Carriage Hill Drive Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Flohr's Church Cemetery Dec. 5,2006 McKnightstown, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, MD 21742 untort uny 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consumence of: Examine nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No certificate 1 ☐ Yes 2 ₹ No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 🕱 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 🛣 No this After thi 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation | Director: / 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Eseph M. Haggerty M. D32407 December 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) [] TUSEPH MERICAL CAMPUS PRIVE 5H 11+ 70 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			1 - For Stete Registrer		aryland / De	partme ertifica			Re	g. No.	U5	4047
	Physic	ian	1. Decedent's Name (First, Middle, Ethel Minerva G						Date of Death Month	Day	Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution,			4b. City	, Town, o	r Location of Death	December	4c. Count	v of Death	3:15 AN
12	LAGITI	101	Washington Coun			, ,		erstown			Washi	ngton
	Funeral Director		216-22-9504	5. Sex 7. Ag 1 ☐ M 2⊠ F	ge (In yrs. last birthd 78 Yrs	Months	or 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 17,	^{Year)} 1928	9. Birthpl Count Mary	lace (State or Foreig try) 1 Land
	Maryland -f ehow	tor	Usual Residence of Decedent	ington	10c. City, Town or	Location Lagers	town				10	0d. Inside City Limits
	deeth with the Marylan ems 23a or 28a-f ehow ir must be notified at	Funeral Director	10e. Street and Number 611 George Str	eet		10f. Zi	ip Code	2174		g. Citizen of	What Coun	try?
980	or It	b	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 1 If Yes, Give Year or Dates:				lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e by: W	
5-0	"neturel",	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. De	cedent's Usu	ual Occup	ation during most of work d)	ing 1	6b. Kind of B	usiness/Ind	lustry
21215-0036	be filed within ital Hygiene. Id other then "event, the Mai	Completed	Elementary/Secondary (0-12)	College (1-4or	0+)	tress	use retired	d)		leparti	nent s	store
Maryland	should be file nd Mental Hy marked oth matic event	To Be (17. Father's Name (First, Middle, La Harry Gettel	est)					e (First, Middle, M Jones	aiden Sumar	ne)	
Mary	2 2 3		19a. Informant's Name/Relationship Cathy Sacco – d					and Number or Run				
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		20b. Place of Discemetery, of Cedar I.			ark 12/9		Oc. Location	-	wn, State Maryland
Baltir	permit. Page Depertment o Importent: If any Injury or once.		21. Signature of Euneral Service Lie		- ()	22. Name a	ind Addre		INNICH F	UNERAL	HOME	
	Physician /Medical Examiner	ılner	23a. Part : Enter the disease, if or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Cuyo Due to (or as	the death. Do not not not at A a consequence of):		de of dyin		or respiratory arres			Approximate Interval Between Onset and Death AM AM
68760,	death certificate be executed e attending physicien and od for use as the burral-transit	dical Examiner	Cause (Disease of Highly that initiated events resulting in death) Last	c. $A = A$ Due to (or as	a consequence of):	t uc.	UHE	Were	ary Ol	· Loc		217
P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _i					te of deliver	y Day Year
Records, P.	The law requires thet the ate has been signed by th page 2 should be detache	6	Part II. Other significant conditions	s contributing to death b	ut not resulting in the	underlying (cause give	en in Part I.		cco use cont		a cause of death?
II Reco		Completed							24a. Was an autopsy performe	d?	Were autop prior to com death? 1 \(\sum \text{Yes} \) 2	sy findings available pletion of cause of 2 No
of Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	/					Check only one			
5	this c	은	1 ☐ Yes 2 ☑ No	Hospital: 1 Unpatie				4 Nursing Ho	me 5 Residen	ce 6 □Oth	er (Specify))
Division (ding After fune	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		ry 28b. Time (Year) Injury	of A	28c. Injury Work 1 🗆 `	yat (? Yes 2 □No	28d. Describe how	injury occuri	red	
DİVİ	tal or Attents after deatl	Certification;	3 Suicide 6 Could not determine		ury - At home, farm, c. (Specify)	street, factor	y, office		28f. Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying (Check only one)	Physicien: To the best of aminer: On the basis of and manner sta	examination and/or	ath occurred investigation	at the time o, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and ma e and place,	inner as sta and due to t	ited. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29	c. License	number	290	I. Date signe	d (Month, D	Pay, Year)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2323

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hy, Uld 2/740 31. Date filed (Month, Day, Year) Opal

State DEC 0 7 Registrar

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrer			Ce	rtificate	e of l	Death			Reg. No.		
0	Discosio:		1. Decedent's Name (First, Middle, La.	st)							2. Date of D Month	eath	Voca	3. Time of Death
	Physici /Medio		WINONA JEAN GARN	AND							DĚČEMI	BER 4,	2006	0302 M
	Examir		4a. Facility Name (If not institution, given 10435 CRYSTAL FA				4b. City,		Location of		N	4c. Cou	unty of Death WAS	HINGTON
	Funeral Director		219-44-3004	X M 2□F	7. Age (In y	rs. last birthday) 1 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, D APRIL 2	irth Pay, Year) 4, 1945	9. Birth	nplace (State or Foreign unitor) SI VIRGINIA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation							10d. Inside City Limits
	he Mary 28a-f sho	Director		NGTON			1.01		GERST	OWN				1 ☐ Yes 2 🛣 No
	with tage or 3	ā	10e. Street and Number 10435 CRYSTAL FA	LIS DRT	WE.		10f. Zip	Code	2174	2		10g. Citizen		untry? S.A.
	ns 23	era	11. Marital Status	12 Was Dece	edent Ever in	n U.S. 13.	Was Deced	lent of Hi			cify Yes or N	0- 14.6	Race - Ameri	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, Ita Medical Exactinational ke notified at	by Funeral	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 Yes If Yes, Giv Year or Da	re	i	If Yes, spec 1 ☐ Yes		n, Mexicar Specify:		cify Yes or N Rican, etc.)		Black, White	
2-0 2-0	72 ho natui	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece	dent's Usua kind of wor	I Occupa	ation during mos	t of workin	na	16b. Kind o	of Business/Ir	ndustry
2121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DONOTUS	e retired MEMA)				OWN I	HOME
Maryland 21215-0036	2 should be file and Mental Hy Is marked oth aumatic avant	To Be	17. Father's Name (First, Middle, Last) JOHN LEO CAIN									e, Maiden Sun STOTLER		
lar	2 sho and is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	oer, City or To	wn, State, Zi	ip Code)
	1 and 1ealth 1m 27 ther ti		RALPH E. GARNAND	, SR.	301	1043 D. Place of Dispo			FAL		RIVE, I	IAGERST		
Baltimore,	Page ent c nt: If ry or		1 Nurial 2 □ Cremation 3 □ 1 □ Cremation 3 □ 1 □ Cremation 3 □ Other (Specification)	<i>(</i>)	State	cemetery, cre	matory or of	ther plac		2/7/2			on - City or T LLE, I	MARYLAND
ga	permit. I Departm Importa any inju		21. Signature of Furieral Service Licer	S89		2:	2. Name an					OLD NAT		
	1		23a. art1. Inter he hand, or comy shock, art failure. List only Immediate Cause (Final	olications that co		3	ter the mode	e of dying	g, such as	cardiac o		BORO, M	IAKYLA <u>I</u>	ND 21713 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (sequence of):	Bree	st.	(a)	~((~				6 weeks
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		or as a cons	sequence of):								
68/60,	certificate be executed iding physician and ise as the burial-transit		resulting in death) Last	Due to (or as a cons	sequence of):								
9	certificate buding physic	/Medical		d										
O. Box	death e atter id for u	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 ∏ Fi ant at time o	etal death 3	Ectopic pre Other (spe			 			Date of deliv Month	very Day Year
rds, P.	8 50		Part II. Other significant conditions o	ontributing to de	eath but not r	resulting in the u	nderlying ca	iuse give	n in Part I.			tobacco use c		the cause of death?
Vital Records,	e taw has b	Completed									24a. Was auto perfo 1 \(\text{Yes}	s an 24 psy primed? 2 No	b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
E	iiclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only			
0	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No			☐ ER/Outpatier		A Cthe	r: 4 □ Nu	rsing Hom	ne 5 Resi	dence 6 🗆 0	Other (Specia	fy)
	ng ftei ne	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		of Injury h, Day Year)	28b. Time of Injury	f 28	Bc. Injury Work 1 🗆 Y	at ? ′es 2 □ !		8d. Describe	how injury occ	urred	
DIVISION	tal or Attandi rs after death. al Diractor: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined	280. Place	of Injury - Al ng, etc. <i>(Spe</i>	t home, farm, str ecify)	eet, factory	office		2	8f. Location (City or To	Street and Nu wn, State)	mber or Rura	al Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the liner: On the ba and mann	isis of exami	knowledge, deati ination and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and date and place	manner as s e, and due to	stated. o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0 .			29c.	License	number			29d. Date sig	1 1	
			Muchael J.	Welin	and	MB.		00	116	67		12	14/0) (
61			30. Name and address of person who			tem 23a) (Type,	Print)	1 - 1	,	/		12	1	un MB
ント	1-4		31. Date filed (Month, Day, Year)	32. B	ec (C agistrar's Sig	////	0 1	ned	reel	600	mos	1725 C	かんいん	va MB
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec 13, 2006 **Physician** Elizabeth Humbertson 0235 M Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frostburg Village Nursing Home Frostburg Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Feb 11, 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 ☑ F Months Hours 215-18-8980 Director 86 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show 10d. Inside City Limits other traumatic avant, the Medical Examinatinust be notified at MD Allegany Cumberland Director M☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 21502 14821 Viewcrest Road S.W. USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2☐No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: white 3 Widowed 4 ☐ Divorced Year or Dates: natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home othar permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is markad othe any injury or other traumatic avant, sines. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Swach Dora Kelly Swach ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Flural Route Number, City or Town, State, Zip Code) 14821 Viewcrest Road SW Cumberland MD 21502 Greg Humbertson son 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 12/18/2000 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nan**Scal belli**r Punellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis Syndrome disease or condition resulting in death) one month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 he 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl 24a. Was an performe 2 No 2 No 1 Yes 1 Yes Hospital or Attanding Physician: ral director 25. Was case referred to medical 26. Place of Death Check only one) examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide illed in within 24 hours af To tha Funaral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) workok the 00055325 Dec 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) io WONSOCK SHIN MD 48 Turn Terrace MD 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

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State Registrar

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Year)

31. Date filed (Month, Day,

tone

32 Registrar's Signature

		•	For State Registrar	S	tate of	Maryla	nd / Depa	artmen rtificate	t of H	ealth a		lental Hy	giene ()	36	No. of the last of	75
* j	Physici		1. Decedent's Name (First, Mic		oio.	LJ.	onkino					Date of De Dec 12	ath 2006	Year 7	3. Time of E	Death M
. 8	/Medic	al .	Robert 4a. Facility Name (If not institut	Fran			opkins	4h City	Town or	Location o	of Death	Dec 12	4c. Count	of Death	.usam	
-	Examin	er	Frostburg Villag	-				Frost					Allega			
	Funeral Director		5. Social Security Number 220-44-6294 Usual Residence of Decedent	6. Sex X □ M		Age (In yrs	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird May 17	^h 1920	9. Birth	place (State or	Foreign
	Maryland 8-f show iffed at	tor	10a. State 10b. Cour	gany		10c. C	ity, Town or Lo Cumb		d						10d. Inside City ★□Yes	
	th with the 23a or 28	Funeral Director	10e. Street and Number 941 Bishop Wa	ılsh Ro	ad Ap	t 4		10f. Zip		1502			10g. Citizen of US		ntry?	
0036	virthin 72 hours after death with the Maryland tiene. Then "natural", or Items 23a or 28a-f show the Madical Examinal numbles notified at	ρ	11. Marital Status Never Married 2 M 3 Widowed 4 Divorc	arried ed	Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	es? ∐No		1□ Yes	2 No	Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	Specil	ck, White, White	9	
Maryland 21215-0036		Completed	15. Deced (Specify only high Elementary/Secondary (0-12	T	on mpleted) College (1-4	or 5+)	16a. Dece (Give life. catholic	dent's Usua kind of wor DO NOT us pries	rk done d se retired,	ition luring most)	t of worki		16b. Kind of B Church	usiness/In	dustry	
land	d la d	To Be (17. Father's Name (First, Middle Frank M. Ho							18. Mothe Mari	e G.	McDerr	Maiden Sumai nott Hop	okins		
	12 sh hand 7 lsm traum		19a. Informant's Name/Relation Mary Margaret	nship (Type, King	^{Print)} frier	nd	4 Hor	ng Address nestead	(Street a d Ave	nd Numbe nue	or Rura	Cumb	er Gity or Town erland	State Zin	°21/502	
Baltimore,	S = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		oval from Sta	20b.	Place of Dispo cemetery, creat Mary's Co	osition (Nam matory or o emeter	ne of ther place y	e)		oate 2/15/2006	20c. Location Cumbe		own, State)
Balti	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service	e Licensee	M	11.	22					me, PA Cumberl	and, MD 2	21502		
			23a. Rart / Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complicati st only one c	Ather	n line. Oscle	notre				^				Approximate Interval Betw Onset and Do	/een
														,		
.O. Box 68	The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		If yes, outco 1 Live birtl 4 Pregnan 9 Unknow	n 2 ∏ Fet tattime of	al death 3	□Ectopic pro □ Other (sp						te of deliventh	,	ear
rds, P	w requires that been signed b should be deta		Part II. Other significant cond	249	uting to deal	_	1.	nderlying ca	ause give	en in Part I.			obacco use con res 2 No	tribute to t	2 44	eath? nknown
		Completed by				 						24a. Was autop perio 1 Yes	rmed?	Were auto prior to co death? 1 \(\text{Yes}	opsy findings a empletion of car	vailable use of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	al	ital·				Othe			Check only o			ink.	- 12.5
ō	Phys this raldii	To To	1 ☐ Yes 2 No 27. Manner of Death	1	1 ☐ Inp		⊒ER/Outpatier 28b. Time o		8c. Injury Work	4 Nu			tence 6 Oth		fy)	
ion	Attending I death. ctor: After y the funer	atior	1XNatural 5 ☐ Pen 2 ☐ Accident inve	ting stigation	(Month,	Day Year)	Injury	М		:? /es 2 □ ì	No					
Division	al or Attend s after death al Director: ,	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	d not be mined 2	8e. Place of building	Injury - At , etc. (Spec	home, farm, sti	reet, factory	, office			28f. Location (S City or Tox	Street and Numi vn, State)	per or Rura	al Route Numb	h⊖∕,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical (29a. Certifier 1 Certif (Check only one) 1 Medic	ring Physicia al Examiner:	on: To the be On the basi and manne	s of examir	nowledge, deat nation and/or in	h occurred vestigation,	at the tim	e, date and pinion, deat	d place, th occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as s and due to	tated. o the cause(s)	
	To t withi To ti	Σ	29b. Signature and title of certification	hell	h	^	10		License	number	25	1	29d. Date signe			
	V		30. Name and address of person					Print)				MD 2		4	2006	
	Sta Registi		31. Date filed (Month, Day, Ye.		32. Reg	istrar's Sigr	M Tex	arti		- 1 1/	3					

			**	Maryland / Depa	artment of Health and		9
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death	Reg. I	
	Physici	an				Month E	Day Year 3. Time of Death
	/Medic		Barbara L. Wells F		45 Ob Town 1 2 4 Day		11,2006 2:50P M
	Examin	er	4a. Facility Name (If not institution, give street and num		4b. City, Town, or Location of Dea		4c. County of Death
			2505 Bellefield Court 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Fort Washing	ton I	Prince Georges
	Funeral Director		1 □ M 242 F	62 Yrs.	Months Days Hours Mir	n. (Month, Day, Yea	
			578-60-3080 Usuel Residence of Decedent	02		April 17	,1944 Wash.,DC
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Mar Mar	to	Md. PG	Fort Wa	shington		1 🙀 Yes 2 🗆 No
	h the	Director	10e. Street and Number	TOTO NO	10f. Zip Code	10g. (Citizen of What Country?
	h wit	ᇛ	2505 Bellefield Cour	+	20744	IIn:	ited States
	dea m	ner		dent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
9	after or ite	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes . Give	2 🔂 No	1 ☐ Yes 252 No Specify:	into ritoani, etc.)	
8	ours	d b	3 ☐ Widowed 4 ☐ Divorced Year or Da		TE 165 ZE 140 Specify.		Specify: Black
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28s-f show ha Medical Examinar must be notified.	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of w	orking 16b.	Kind of Business/Industry
121	within ene. than	E E	Elementary/Secondary (0-12) College (1-	4or 5+)	DO NOT use retired)		
	Hygie Hygie thar t		10	Human	n Services Spe	-	Government
and	ould be fi Mental H arked ot atic ever	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Examinar must be notified.	2	Morris Brown			ce Coghil	
Z	12 st h and 7 te r traun	()	19a. Informant's Name/Relationship (Type, Print)	2505	ng Address (Street and Number or F Bellefield C	Rural Route Number, City Ourt	y or Town, State, Zip Code)
	1 and Heelth em 27 Ither tr		Juana Wells/daughter 20a, Method of Disposition	Fort	Washington, I	Md. 20744	Laureline City of Town Conta
ō	Peges nent of h ant: If ite ary or of		1 ☐ Burial 2 ☑Cremation 3 ☐Removal from S	tate cemetery, crei	matory or other place)	1	Location - City or Town, State
Ë	tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)				Riverdale, Md.
Baltimore,	permit. Peges Department of Important: If it any Injury or one		21. Signature of Funeral Service Licensee	1)	2. Name and Address of Facility	Hodges & I	Edwards F.H.
	002 # Q		yanice caud	an 39	10 Silver Hil	l Rd., Sui	
	Physician		23a. Parl 1. Enter the disease, or complications that ca stock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death
1	/Medical Examiner		Due to (c	r as a consequence of):	cer Yrenlan accid	′ 4	
		-	Sequentially list conditions,	ras a consequence of:	efeniar accid	en/-	
4	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
Ma	siclen and burial-transit	xar	that initiated events c.	r as a consequence of):			
3760/2	death certificate be executed e attending physiclen and of for use as the burial-transit	cal	4				
687	ficate p phys		U.				
Box	leath certifical attending phy if for use as th	Physician/Med		ome of pregnancy			23d. Date of delivery
_	death a atte d for	Cla	in the past 12 months? 1	nt at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
P.0.	that the de led by the a detached t	hys	9 ☐ Unknown 9 ☐ Unknown	wn			
	The law requires that the set has been signed by the page 2 should be detache	by P	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	ndertying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	quire on sig uld b		Congestive hear	+ failure		1 ☐ Yes	2 No 3 Probably 4 □Unknown
Records,	s been s	Completed	,			24a. Was an	24b. Were autopsy findings available
Be	The lay	E				autopsy performed?	
of Vital		BeC	25. Was case referred to medical		26 Place of De	1 Yes 2 1 Nes	√lo 1 □ Yes 2 🔯 No
<u>></u>	Physician: this certific al director,	To B	exeminer?	patient 2 ☐ ER/Outpatier	Other	Home 52 Residence	6 □Other (Specify)
0			27. Manner of Death 28a. Date of	Injury 28b. Time o		28d. Describe how in	
Ö	ttending F death. ctor: After y the funer	atlo	1 ⊠Natural 5 □ Pending (Month 2 □ Accident investigation	, Day Year) Injury	M 1 Yes 2 No		
Division	or Attendente of the or or Attendente of the or or or or or or or or or or or or or	=======================================	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of buildin	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office	28f. Location (Street a	and Number or Rural Route Number,
Ö	s efter s efter al Dirac	Certification;	Buildin	g, etc. (Specify)		City of Town, Sta	110)
	To the Hoepital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the tagency 2 Medical Examiner: On the bar and manner	sis of examination and/or in	n occurred at the time, date and place vestigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Dey, Year)
			Mary W Willen	2 12	055258	De	reml = 12 2 mm/
	5		30. Name and address of person who completed cause	of death (Item 23a) (Type,		300	when 12, 2006
	v)		Grown B. Wilks, w.D.	10200 01	d Columbia Ro	and Colum	ilin marchan 1 2046
							7
	Sta Registr		31. Date filed (Month, Day, Year) 32.46	gistrar's Signature	medis		

			1 - For Stata Registrar	State of M	aryland				ealth a Death	and M		iene2 ()	06	40	477
	Physic	an	Decedent's Name (First, Middle, Last)							Date of Deat Month	h Day	Year	3. Time	of Death
	/Medi	cal	Dorothy Mil								Decembe		006		5 p. M
	Exami	ner	4a. Facility Name (If not institution, give						Location o	of Death		4c. County			
	Funeral		Mallard Bay Care 5. Social Security Number 6. Se		ge (In yrs. las	st birthday)		ambr.	lage	24 Hrs.	8. Date of Birth		rche		e or Foreign
	Director]M 2∏F	93	Yrs.	Months		Hours	Min.	(Month, Day, March	Year)		arvla	e or Foreign nd
	D.		Usual Residence of Decedent								- Parcil A	20, 191	J 17	aryra	IIG.
	aryla ehov	_	10a. State 10b. County	+ ~~	10c. City,	Town or Lo	cation	Com	hand 170						City Limits
	after death with the Marylan or Items 23s or 28s-f show ruiner must be notified at	Director	MD Dorches	rer	<u> </u>		1		bridg	е					es 2□No
	with	ä					10f. Zip		C1 2		1	0g. Citizen of \		intry?	
	Jeath ms 23	Funeral	520 Glenburn A	12. Was Decedent	Ever in U.S.	13.1	Was Dece		613	nin? (Sne	acify Yes or No-	USA 14 Bac		ican fndian.	
က္	or Iter	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X	?	11			n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ck, White		
03	72 hours after death with the Maryland natural', or Items 23s or 28s-f show alcal Examinat must be notitled at	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I □ Yes	2 X No	Specify:			Specify	·: wh	ite	
5-0	"natural", o	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	kind of wo	rk done d	urina most	of worki	na	16b. Kind of Bi	usiness/Ir	ndustry	
121	d within giene. rr then "	m	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT u	se retired)					,		
7		e Co	unknown 17. Father's Name (First, Middle, Last)				hc	mema)		re Name	(First, Middle, A		hom	e	
an	d be antal ced o	To Be	Benjamin Frank	lin Deatr	rich						iley	naiuen Suman	10)		
Maryland 21215-0036	shoul nd Me mari	F	19a. Informant's Name/Relationship (T)			19b. Mailin	g Address	(Street a			il Route Number,	City or Town	State Zi	n Code)	
	permit. Pages 1 end 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any niury or other traumatic event, ang.		Doris H. Weber	daught							Cambrid		216		
Baltimore,	of Hern Item		20a. Method of Disposition		20b. Plac	ce of Disponetery, crem						20c. Location -	City or T	own, State	
Ē	Page nent ant: H		1 S Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State	1	heste				12/6	6/06	Cambri	dae.	MD	
alt	Departr Departr Importu any nj		21. Signature of Funeral Service Licens	99					s of Facility		omas Fur				
<u> </u>	20 E 2 9		D_K.B=)		70	00 .Lo	cust	st.,	Can	bridge,	MD 21	613		
8760,	physicien and physicien and physician transit sthe burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sought list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	a consequer a consequer	nce of):	c an	cer m						Interval B Onset an	d Death
P.O. Box 6	The law requires that the death certific lie hes been signed by the ettending p page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	eath 3	Ectopic pr Other (sp					23d. Dat	e of deliventh	ery Day	Year
	w requires that been signed should be det	by	Part II. Other significant conditions con dementia	ntributing to death b	ut not resultin	ng in the un	derlying c	ause giver	n in Part I,			acco use contr		he cause of	
Division of Vital Records,	The law requite hes been sage 2 should	Completed									24a. Was an autopsy perform	ed?	rior to co leath?	ppsy finding mpletion of	s available cause of
ita	ysician: The is certificete he director, page	Bec	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes 2. Check only one	•	☐ Yes	2 No	
× ×	Attending Physician: r death. sctor: After this certifict by the funeral director,	2	1 ☐ Yes X ☐ No	lospital: 1 🔲 Inpatie	ent 2 ER	VOutpatient	3 DC	A Other	4 Nur	sing Hon	ne 5 🗆 Resider	nce 6 🗆 Othe	er (Specif	iy)	
בַ	ing P		27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28 y Year)	Bb. Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe how	v injury occurr	ed		
<u>s</u>	tendi feath for: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2□N	lo					
Ξ	7 6 F C	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At home c. <i>(Specify)</i>	e, farm, stre	et, factory	, office		2	28f. Location (Str. City or Town,	eet and Numbe State)	er or Rura	d Route Nu	m <i>ber</i> ,
_	To the Hospital or Attending Ph within 24 hours eliter death. To the Funeral Director: Aller th completely filled in by the funeral	edical Ce	29a. Certifier 1 Cartifying Physic (Check only one) 2 Medical Examination	ier: On the basis of	r examination	edge, death	occurred estigation,	at the time in my opi	e, date and nion, death	place, a	and due to the car	use(s) and mai	nner as s	tated.	(s)
	o the	Med	29b. Signature and title of certifier	and manner sta	2.60.			License				d. Date signed			
1	⊢ \$ ⊢ ŏ		and and	<u> </u>	(L)				1599	97=		12/4	/		
		-	30. Name and address of person who co	mpleted cause of d	leath (Item 2	3a) (Type F		,				15/1	109		
			Patricia Jo	hnson, D.				le S	t., c	ambr	idge, MI	2161	3		
	Sta		31. Date filed (Month, DEC 0 6	32. Reoffit	ar's Signature		1	d -							
	Registr	ar		EUUU MA	BORE A	100	1.80								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

40478

			Certificate of Death		g. No.		1041	O
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	<u> </u>		3. Time of Deat	ith
	Physici		William Homer Healey, Jr.	Month November	Day 29. 20	Year	2:45	PM
7	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or L		4c. County		2.45	
			Maryland Masonic Home Hunt Vall	ev	Baltin	nore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) if Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Vear)	9. Birthplac	e (State or For	reign
	Director	Ŋ.	219-01-4493	Sept.14,	1917	Mary1		
	/land		10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Lin	mits
	Man Hear	호	Maryland Baltimore Hunt Valley				1 □ Yes 2 □	AND
	h the	Funeral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of V	hat Country	?	
	h wit	<u>=</u>	300 International Circle 21030	II	nited S	States		
	deat	ner	11. Marital Stetus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (St		14. Race	- American	Indian,	
020	72 hours after death with the Maryland netural', or flems 23a or 28a-f show disel Examiner must be notitied at	by Fu	1 Never Married 2 Married 1 Never Married 2 Name of the State of the S	rican, etc.)		k, White, etc · Whit		
Baltimore, Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be notitied at once.	To Be Completed by	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work done during	cing 1	6b. Kind of Bu	siness/Indus	try	
212	y with	E	Elementary/Secondary (0-12) College (1-4or 5+) Musician		U.S.	Navy		
b	offile offile offile rent,	e C	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M	aiden Surnam	е)		
<u>a</u>	Ald by Al	0	William H. Healey, Sr. Olive E.	Walbert				
ar	s mai	Γ,	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru					
Σ	end 2 selth 127 i		Madeline L. Healey / Wife 300 International Circ	le # 336	Hunt V	/alley	, MD 21	03
nore	eges 1 int of He t: if item y or oth		20a. Method of Disposition 1) Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Mem. Gardens	Date 20 2/2/2006	Oc. Location -	•		and.
Ħ	artme ortan injur							
Ba	Depar Impor		1. Signature of Funeral Service Licensys 22. Name end Address of Facility Jo 147 Duke of Glouce	nn M. lay ster St.	Annapo	neral lis, N	ноте, 1D 2140	1
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiretory erres	st,	Ar	proximate tervel Between	
	Physician /Medical Examiner		,			O	nset and Death	1
		ner	Immediate Couse (Finel disease or condition resulting in death) End That Dementin Due to (or as a consequence of): A Der Scheratin: Vas culan Dis	ease		0	Joers	
	rtificate be executed ng physician and s as the buriel-transit	Examiner				1	7	
80,	oe ex cian (Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
68760,	cate physi	Medical	that initiated events resulting in deeth) Lest Due to (or as e consequence of):					
×	ding se as		d					
Box	eath ce ettendi I for use	ciar	THE REAL PROPERTY OF THE PROPE					
Ö	the de	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.				e cause of dea	
s, P.O	v requires that the death or been signed by the ettend should be deteched for us	by Ph	Hypertensin, arthuluto, Coronny arteny	1 ☐ Yes	3 2□ No	3 ☐ Probab	ly 4.2 Unkn	iown
of Vital Records,	The law requires that the death certificate be executed ate hes been signed by the ettending physician and page 2 should be deteched for use as the bunel-transit	Completed	disease,	24a. Wes en performe		eveila	autopsy finding ble prior to letion of cause	
Be	he law e hes age 2	티		1 ☐ Yes	2000	1 🗆 Y		
<u>ta</u>			25. Was case referred to medical 26 Place of Deal	h (Check only one)	, , , ,	101	35 20110	
>	Physicien: rthis certific ral director,	To Be	examiner?	me 5□ Residen		r (Specify)		
9	Phys or this eral di		27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at	28d. Describe how				
Ö	ath. :: Afte	읉	1 ☑Naturel 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No					
Division	or Atter efter dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Numbe State)	er or Rural Ro	oute Number,	
	To the Hospital or Attending Phy within 24 hours efter death. To the Funerel Director: After thi completely filled in by the funeral	edicai C	29a. Certifier (Check only one) 12 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and plece, 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	end due to the cau red at the time, dat	ise(s) and mar e and place, a	nner as state	d. e cause(s)	11/2
	o the	Mec	29b. Signature and title of certifier. 29c. License number	290	d. Date signed	(Month, Day	, Year)	
	⊬ ≯ ⊨ ŏ		101		11-30-	06		
			30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) ROBERT LIBERTO, WD: 3508 BANK ST Ballo			- 10		
	10+1		ROBERT LIBERTO, MD. 3508 BANK ST Balto	no -	21220	1		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrer's Signature		1			

Registrar

WILLIAM HERALEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 1920 M 30 Hamill 11 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death **Examiner** Hospice by the lake Dastal Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 10 M 2 □ F Yrs 22026 1263 Director South Dakota Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Lakeview Drive 21804 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours effer deel Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or itemany injury or other traumatic even. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2□No AirForce
If Yes, Give
Year or Dates: Korea 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hair Stylist Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Howard Hamill, Sr. Edith Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Lakeview Dr., Salisbury, MD 21804 Beverly B. Hamill/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 12/1/06 Salisbury, MD 22. HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Matastatic Colon **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ettending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2/ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to complet in of cause of death? 24a. Was an autopsy 2/3 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA his 27. Manner of locath ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Naturat 2 Accident 5 Pending death. 1 Tes 2 No investigation efter death Director: / filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai mpletely (Check only one) the

State Registrar

DEC 0 4 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

" stal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

General

ORIGINAL

29c. License number

5-11-6 MD 21802

29d. Date signed (Month, Day, Year)

06-09107 Kevin Hardy Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical Examiner November 30, 2006 0812 hrs Kevin Hardy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5 Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Foreign Wash., D.C. Director Months Hours 578-94-5052 1 X M 36 9/8/70 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d Inside City Limits 28a-f show D.C. Washington Yes 2 XNo nours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4408 Lee St., N.E. 20019 U.S.A. 10 items 23a o ust be notifi Funeral 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 2x No Black Widowed Divorced Give Yea 1 Yes 2 X No specify: Specify à 16a Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 l and Mental Hygiene is marked other than atic event, the Medical Baltimore, MD 21215-0036 Vendor Self-Employed 10th 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Ronald Leon Hardy, Sr. Arletta A. Poindexter Be ۵ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arletta A. Hardy-Banks/Mother 4408 Lee St., N.E., Washington, D.C. 20019 Department of Health at Important: If item 27 injury or other traums 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Pages 1 1 XBurial 2 Cremation 3 Removal from State 12/6/06 Harmony Mem. Park Landover, Maryland Donation 5 Other Specify 21. Signature of Funeral Service Licensee H.S. Washington & Sons Co., Inc. any 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a Part I. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that iriniated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED physician AMENDED Division of Vital Records, P.O. Box 68760 IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Day Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? \$ Yes 2 V No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? ✓ Yes 2 1 V Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 DOA Nursing Home 5 After this Residence 6 2 1 🗸 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d Describe how injury occurred Certification: Nov 30, 2006 Subject shot 0721 hrs Natural Yes 2 V No Pending 2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 7800 Greenleaf Road, Palmer Park, MD determined (Specify) Car 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certi 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 1, 2006 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State 32. Registrar's Signature 2006 Registrar

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			1 - For State Registrar	State of M	aryland /		artmeni rtificate			and M		giene Reg. No.	306	40	481
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		4	16919 Alcott Rd.					gerst				Was	shingt	on	
	Funeral		5. Social Security Number 6. S 214–36–1302	ex 7. Ag □M 2127F	ge (In yrs. last i	birthday) Yrs.	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Day	v, Year)	Co	hplace (State untry)	
26	Director		Usual Residence of Decedent		65	113.					Aug. 17	, 194	I Mar	ryland	-
	yland		10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside	City Limits
	a-fet	ţo	MD Washing	ton	На	gers	town							1 □ Y∈	s 2X No
	or 28	ire	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	untry?	
	23a	Funeral Director	16919 Alcott Road	đ			2	1740					U.S.A.	•	
	iteme	- Tue	11. Marital Status	12. Was Decedent Armed Forces?	,	13. \	Was Deced	ent of Hi	spanic Orig	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		Race - Amei Black, White		
36	s afte	by F	1 ☐ Never Married 2 💥 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX If Yes, Give	No		1 ☐ Yes 2	X No	Specify:		,		a a i fe u		
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Maryland	sh and sm		19a. Informant's Name/Relationship (Route Numbe		wn, State, Z	(ip Code)	
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Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme	of Dispo tery, cren	sition (Nam natory or oti	e of her place			ate	20c. Location	on - City or 1	Town, State	
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Baj	permit. Pages Department of I important: If ite ony injury or or		21. Signature of Funeral Service Licer	see							st Have				
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			shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	o not ent	er the mode	or dying	, such as	cardiac or	respiratory arr	est,		Approximation Interval Books and Onset and	elween
	Physician /Medical		disease or condition resulting in death)	a Hrey	8 trop	71 <		416	161	500	01031	15		140	AVS
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9	artifica ing ph e as (Med	IF FEMALE:												
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal dea		Ectopic pre						Date of deliv	- ,	Was -
	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	t time of death	5 🗆	Other (spe	city)					Month	Day	Year
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	To the Hospital or Attanding F within 24 hours effer death. To the Funaral Director: Alter completely filled in by the funer	ical	Crieck only 2 Medical Exam	ysician: To the best	r examination a	ge, death	occurred a	the time	e, date and	place, ar	nd due to the ca	ause(s) and	manner as	stated.	e)
	To the P within 24 To the F complete	Medical	5,707	and manner sta	ated.		-			_ 3031101					<i>¬</i> /
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1	4-10		30. Name and address of person who	completed cause of c	eath (Item 23a) (Type, 8	mnt)	H	4/=	77	Dec Thes	1 1	114	NLO	127
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	711	'	112	146	14)	1 Ful	17)	1/1	JAPP	
	Registr	250	UEC 0 7 20	106 July	a D.	Spe	ende								

			4 01.4	artment of Health and Mental Hygiene rtificate of Death	2000 40402
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Willie Tames Jack	SON. SR. Dec. 3	y Year 2006 8,15 PM
1	Exami Funeral	Щ	4a. Facility Name (If not institution, give street and number) 1 2 5 S. West Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth	County of Death Talbo + 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	Months Days Hours Min. (Month, Day, Year)	147 Alabama 10d. Inside City Limits
3	h the Maryland ir 28a-f ehow	Irector	MD Talbot Eas 10e. Street and Number	stow.	1 ☑Yes 2 ☐ No izen of What Country?
\mathcal{N}_{9}	ours after death with the Marylar ral', or Iteme 23a or 28a-1 ehow Examinar must be notified at	Funeral Director	1 Never Married 2 Married 1 MYes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
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	iled within Hygiene. ther than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Driver Di	Ry cleaner
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be	James Bruce Jackson	18. Mother's Name (First, Middle, Maiden 2 S/ 2 Mae 19. Address (Street and Number or Rural Route Number, City o	Deveridge
Baltimore, Ma	Health tem 27 other tr		Brenda Jackson 125- 20a. Method of Disposition 20b. Place of Dispo	S. West Street Easton, M. sition (Name of natory or other place) Date 20c. Lo	Dakyland 2/60/
Baltir	permit. Pages Department of Important: If i any Injury or once.			2. Name and Address of Facility LEWRY FUNERAL HOME, P. A. LOWESHINGTON ST. COMBri	Lac MD 21613
	Physician /Medical Examiner		23a. Pant. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	er the mode of dying, such as cardiac or respiratory arrest.	Approximate Interval Between Onset and Death Mainths
8760,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	USO	y ens
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of Vi	g Physician: er this certific eral director,	n: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury, 28b. Time of		
Division	To the Hospital or Attending Physician: The law within 24 Purous after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 XNatural 5 Pending (Month, Day Year) Injury 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	M 1 Tes 2 No	d Number or Rural Route Number,
	Hospital	edical Ce	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death one) And manner stated. And manner stated.	occurred at the time, date and place, and due to the cause(s) estigation, in my opinion, death occurred at the time, date and	and manner as stated. place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier plug & (Phy Si Ciaz		e signed (<i>Month, Day, Year</i>)
			30. Name and address of person who completed cause of death (Item 23a) (Type, F. Muhammad E197 M.D. 83a C	hesapeake Dr. Cambridge	MD 01617
(C)	Sta Registr	ite ar	31. Date filed (Month, Day Year) 32. Registrar's Signature	loneth !	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Volumber 29 2006 **Physician** ane asman 11:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia Howas Howard County General If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Davs Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 7 F 244-50-9517 Yrs Director 12/24/1933 North Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Howard Maryland Fulton 1X Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or Itema 23a 20759 12536 Lime Kiln Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 21 No ğ 3X Widowed 4 ☐ Divorced "naturel". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Telephone Representative Telephone Company permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oths any Injury or other traumeth. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clement Price Dorothy Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Smith - Daughter 12536 Lime Kiln Rd., Fulton, MD 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 12/2/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 BAUGE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) an Physician no /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): • Examine use as the burial-transit Due to (or as a consequence of) physicien Physician/Medical nemi IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Day Year 4□Pregnant at time of death 5 Other (specify) Yes 2X No 9 Unknown 9 Unknown cate hes been signed by pege 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending death. investigation 1 Yes 2 No completely filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) NOU Coulses 3 11h 050870

State Registrar

Baltimore,

Box 68760

P.O.

Records,

31. Date filed (Month, Day, Year)
DEC 0 4 2006

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bell Lane Clarksuille SUZAN Abdo MD 5005 Figure Bell Lane Clarksuille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nonth Le C Year 109P 011 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Medica FIMORE If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month Day Year) 9. Birthplace (State or Fore Country) Pennsylvania If Under 1 Year **Funeral** 9. Birthplace (State or Foreign 1 M 2 □ F 170-34-1085 65 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 5 2909 Ram Road 21613 Completed by Funeral USA 12. Was Decedent Ever in U.S. Amper Forces? 1 ☐ Yes. 2 ☐ No I Yes, Give Year or Dates: 1960-64 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Senior Pellotologist Electronic 12 other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Nicholas Koshar Mary Elizabeth Rakar 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin T. Koshar/Son 2909 Ram Rd., Cambridge, MD 21613 itam 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of himportent: If its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCenter 12/2/2006 Cambridge, MD 1/Signa ure of Funeral Service Licensee ²² Name and Address of Facility Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Intra cerebra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending physic 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death P.O. 1 signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by should t 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Accident Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1 2006 rson who completed cause of death (Item 23a) (Type, Print) Bultimire, Maryland h breeze 31. Date filed (Month 32. Reg State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygier ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER™5, 2006 **Physician** 1724 м KNOTT FRANCIS EDWARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BOONSBORO 403 ELM CREST **AVENUE** WASHINGTON 8. Date of Birth (Month., Day, JAN . 4, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 MM 2 □ F 220-32-6248 70 WASHINGTON, DC Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 1 ¥ Yes 2 □ No Director MARYLAND WASHINGTON BOONSBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 ELM CREST AVENUE 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Madical Exempton 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICIAN ELECTRICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS KNOTT. SR. ANNA DUGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDY KNOTT, WIFE 403 ELM CREST AVENUE, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY 12/6/2006 SMITHSBURG, MARYLAND 21. Signature o Funeral Senice Licensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Con hear 6 monto /Medical Due to fer as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasmic. Examiner Due to (or as a consequence of): requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown COPD Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2/2 No 1 Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Tes 2 No Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D32518 12/6/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Guedenet, 21 Wyand Drive, Keedysville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 2006

DHMH 17 Rev 1/200

Registrar

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	Physici /Medi		1. Decedent's Name <i>(First, Middl</i> e, <i>L</i> Nancy		arie	Kiefer		2. Date of Deat Month Novembe	Day Year	3. Time of Death 8:20 AM
	Examir		4a. Facility Name (If not institution, gi	ve street and number,		4b. City, Town, or	Location of Death		4c. County of Death	
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	Funeral Director		040-56-5556	1 N OM C	ge (In yrs. last birthday 39 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/25/1	Year) Cour	place (State or Foreign htry) IECTICUT
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation.			1	Od. Inside City Limits
	Many -1 sh	tor	MD Alleg	anv	Cı	umberland				1 X Yes 2 □ No
	h the	Director	10e. Street and Number	,		10f. Zip Code		10	0g. Citizen of What Cour	ntry?
	th wit		426 Furnace	Street		21	1502		USA	
36	d within 72 hours after death with the Maryland Jiene. r than "naturel", or Items 23a or 28a-1 show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2√ No	spanic Origin? (Sp., Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
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Baltimore,	00		1 ☐ Burial 2 🏻 Cremation 3 [Removal from State		osition (Name of omatory or other place	I		20c. Location - City or To	
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	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Pancre	the death. Do not ene. 2011 C a consequence of):	incer				Approximate Interval Between Onset and Death
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P.O. Box	To the Hospital or Attending Physician: The law requires that the death certival thin 24 hours atterdeath. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year
S, O	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions					23e. Did toba	acco use contribute to th	e cause of death?
ord	requir	eted	Abdomi	nou i	vound	infect	non	1 ☐ Yes	s 2⊠No 3□Proba	ably 4 Unknown
Division of Vital Records,	n: The law icate has b r, page 2 sl	Completed						24a. Was an autopsy perform	prior to con ed? death?	osy findings available inpletion of cause of
ξ	siclar certil	o Be	25. Was case referred to medical examiner?	Hospital:		100		h /Check only one		
on of	ding Phy	ion: To	27. Manner of Death	28a. Date of Inju (Month, Da	nt 2 ER/Outpatier y Year) 28b. Time of Injury	f 28c. Injury	at	28d. Describe hov	nce 6 Other (Specify w injury occurred)
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	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exact	nysician: To the best niner: On the basis of and manner sta	examination and/or in	h occurred at the time vestigation, in my opi	e, date and place, nion, death occur	and due to the cau red at the time, dat	use(s) and manner as sta te and place, and due to	ited. the cause(s)
	To th Withir COMP	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Month, D	Day, Year)
1	nv		11/10 N.C	laisrai	w	D006	4167	No	vember 20,	2006
	3		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type,			T TOTAL	04500	
			N. Vaisra		47 Virgin		Cumber 1	land, MD	21502	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30TH, 2006 **Physician** NOVEMBER 16:00 M Mary Katherine Kessel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 🖫 F 83 233-78-2585 June 14, 1923 Director Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1∏Yes 2∏No Director MD Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 156 N. Mechanic Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Coleman Pear1 (Stewart) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traum once. 156 N. Mechanic St., Cumberland, MD 21502 Ellen Beck / granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 12/01/2006 | Cumberland, MD 21. Signatury of Fineral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, P.A. rulet 404 Decatur St., Cumberland, MD 21502 Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shock Physician day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nemoma Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). cervacedosis The law requires that the death certificate be executed attending physician and for use as the himal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4☐Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 文 Únknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? 1 ☐ Yes 2 ☐ No certificate 2 XNo or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 28a. Date of Injury 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) (Month, Day Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29b. Signature and title of cerlifier 29d. Date signed (Month, Day, Year) D60478 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 625 KENT AVENUE, SUITE 102, CUMBERLAND, AFAO, M.D., AHMAD, 31. Date filed (Month, Day, Year, State 1 2006 DEC 0 Registrar

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Funeral			S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth		lace (State or	Foreign
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and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City	y Limits
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thould nd Me mark matic	ို	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a		he Thoma		vn State Zin	Code)	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service (benfee		22	Name and Addres Hardesty 12 Ridge	s of Facility Funera	l Home,	P.A.	MD 21	401	
E #		23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that only one cause on e	caused the death	h. Do not ente					1110 21	Approximate Interval Betw	ioon.
Physician		Immediate Cause (Final disease or condition		~~9	ca	ncer					Onset and D	
/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):	1/4					<u> </u>	.00
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attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1□Live I	tcome pf pregna birth 2□Feta nant at time of d	l death 3	Ectopic pregnancy				Date of delive Month	,	ear
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iclan; certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Dea	ath (Check only	one)			
Phys r this ral dir	ှို	1 Yes 2 No 27. Manner of Death	28a. Date		28b. Time of	3 DOA	4 Linursing F		idence 6 🗆 0		/)	
th. : Afte	tion	1 Natural 5 Pending 2 Accident investiga	(Mon	nth, Day Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2∐No	Lou. Dosonbo	now injury ooc	uned		
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ital or irs afte ral Di	Cer								,			
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	edical	29a. Certifier (Check only one) Certifying 2 Medical E	xaminer: On the b	e best of my kno pasis of examina iner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and place pinion, death occu	e, and due to the urred at the time	cause(s) and , date and plac	manner as si e, and due to	ated. the cause(s)	
ro the vithin ro the comple	Me	29b. Signature and title of certifier				29c. License	number	T	29d. Date sig	ned (Month,	Day, Year)	
		Man	an 1	ND		D:	3950	5	Nover	nser	30,20	06
5		30. Name and address of person w	2011200	205	Hachil	al DV.	3950 Glen B	umi	e, M!	> 21	061	
Sta Registra	te ar	31. Date filed (Month, Day, Year) DEC 0 4	2006	gistrar's Signa	ture					-		
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		riease i	ype or Print in E				•	•	
		For	State of Marylan				Mental Hygi	ene	1,01,29
		1 = State Registrar		Ce	rtificate	e of Death	Re	g. No.	40407
Dharia		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Physic /Medi		Fortunee Lavigne					November	30, 2006	2:10 PYM
Exami		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or Location of Death	1	4c. County of Dea	ath
		Glade Valley Nursia	ng Home		Wa.	1kersville		Frede	rick
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under	1 Year If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign country)
Director		022-24-2861	M 2対F 81	Yrs.	Months	Days Hours Min.	August 1	1925	France
g		Usual Residence of Decedent							
ylan how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Ma F-f-	cto	Maryland Frederic	k V	Walkers	sville	3			1 √ Yes 2 No
if ied within 72 hours after death with the Maryland Hygiene. Sther than "natural", or itame 23e or 28e-f ahow ent, the Modical Exacting froughte profitted at	Director	10e. Street and Number			10f. Zip		10	g. Citizen of What C	ountry?
h wil		56 Frederick Stree	t			21793		United St	ates
deat m	Funeral		2. Was Decedent Ever in U		Was Deced	ent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	erican Indian,
o all all a	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No			ify Cuban, Mexican, Puert	o Hican, etc.)	Black, Wh	ite, etc.
S in the second	þ	3 🙀 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2	2⊠ No Specify:		Specify:	White
2 hg	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usua	Occupation	fring 10	6b. Kind of Business	s/Industry
nin 7	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	k done during most of wor e retired)	King		
d with	PO	12	- Comogo (· · · · · · · · · · · · · · · · · ·	School	ol Caf	eteria Work	er F	ood Servi	ce
of Hygin	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M.	aiden Sumame)	
lid be ked o	ToB	Ohannis Kara Oglan	ian			Mira Be	euloulou		
ine, intal ylation to a standard and a stand a stand within a stand Mental Hygiene. Item 27 is marked other them other traumatic event, the Men	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address	(Street and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)
Ind 2		John Lavigne / Son		16 Tr	· onma c	ster Ct., Thu	irmont M	0 21788	
Head Head		20a. Method of Disposition		Place of Disponentery, crer	sition (Nam			Oc. Location - City o	Town, State
Doutiliors, IVI		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	miloval monii Stato						W1 1
orther right		21. Signature of Fundral Subtract Conse		thaver				rederick,	
Deperminant in the control of the co		21. Signature of Turner Localization		Ré	sthav	Address of Facility ven Funeral	Services,	Skkot Co	dy P.A.
		and the		9.	our ca	itoctin Mtn.	Hwy. Free	derick, M	0 21/01
		23a. Part1. Enter the disease, or complete shock, or heart failure. List only on	e cause on each line.	n. Do not ent	er the mode	or dying, such as cardiac	or respiratory arres	it, .	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Congestive He	eart Fa	ilure				4 weeks
/Medical		resulting in death)	Due to (or as a conseq	uence of):					
Examiner		Secure distribution of the second sec	Coronary Arte	ery Dis	sease				years
п =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
cute	Examiner	that initiated events							
te be executed ysicien and he burial-transit	Ä	resulting in death) Last	Due to (or as a conseq	uence of):					
te be ystci	ca	d							
The law requires that the death certificate I are table to signed by the ettending physicage 2 should be detached for use as the page 2.	hystclan/Medi								
andir og	5	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna]C-+:-			23d. Date of de	livery
d for	Cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of d		Ectopic pre Other (spe			Month	Day Year
that the death cer ed by the ettendir detached for use	hys	9 Unknown	9□ Unknown						
lires that signed b	by P	Part II. Other significant conditions con	ributing to death but not resi	ulting in the u	nderlying ca	use given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
S S S S S S S S S S S S S S S S S S S		Dementia					1 ☐ Yes	2 ∑ No 3□P	robably 4 Unknown
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ding Physician: The la h. h. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?	ospital:			0.0	th (Check only one)		
a this	မှ	1 105 2 XX 40	1 Inpatient 2					ce 6 ☐Other (Spe	ecify)
ing fi	Ö	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury at Work?	28d. Describe how	injury occurred	
thendi tor: A	catl	2 Accident investigation			М	1 ☐ Yes 2 ☐ No			
ract iract	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory,	, office	28f. Location (Stre City or Town,	et and Number or A State)	ural Route Number,
ed ir	Se								
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	edical	29a Certifier 1 N Certifying Physics (Check only 2 Medical Examin	cian: To the best of my kno er: On the basis of examina	wladge death	occurred a	it the time, data and place	and due to the cau	to(t) and interner a	s stated.
haH in 24 haF plete		one)	and manner stated.	tion and or an	vestigation,		red at the time, date	e and place, and du	e to the cause(s)
Vith To t	Σ	29b. Signature and title of certifier				License number		I. Date signed (Mon	
		DIA K			D	26516	De	ec. 1, 200	J6
1)		30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print)				
• /		Allen Gilson, M.D.	1475 Taney A	ve., E	reder	ick, MD 2170)2		
Sta	ate	31. Date filed (Month, Day, Year)	32. egistrar's Signa	ture					
Regist	rar	DEC 0 6 200	6 Steene	OF RE	all!				

State of Maryland / Department of Health and Mental Hygiene) 40490 For State Registrar #11 per FH/wichd/12-4-06/d1sCertificate of Death Amend item 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day William Layton /Medical DEC 1300 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 XM 2 ☐ F 217-10-3889 Director Yrs. 9-28-1919 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28s-f show 10d. Inside City Limits r than "natural", or itame 23a or 28a-f sho the Medical Exeminer must be notified at Director 1X Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 708 Edgar Drive Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene. 27 is markad other than r traumatic avent, the Mo Elementary/Secondary (0-12) College (1-4or 5+) 9 Hatchery Manager Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William A. Layton Pear1 Mumford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: if item 27 is y or other tra Jack Layton - son 708 Edgar Drive, Salisbury, Maryland 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Pk. 12-5-06 Salisbury, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Fundal Service License 708 E. Main Street, Salisbury, Maryland 21804 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only see cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Andio myopathy Physician schemec /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Exami NSTAGLE Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has perfor rmed? 2 X No 1 ☐ Yes 2 ☐ No 1 Yes Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after ō To the Hospital within 24 hours a To the Funerel C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie, 29c. License number 29d. Date signed (Month, Day, Year) D 34768 duress of person who completed cause of death (Item 23a) (Type, Print) WiELANCE 100E CARNOLL St. SAlisbury Md. JECCREY ms 31. Date filed (Month, Day, Year)
DEC 0 4 2006 32. Registrar's Signature State lower Registrar

	4	For State Registrar	State of Maryla			e of Dea		Re	g. No.	06	4049
Physician		Decedent's Name (First, Middle, Las		_				Date of Deat Month	Dav	Year	3. Time of Death
/Medica	ıl.	FLOSSIE H.	LITTLEJOHN	1				NOVEMBE	R 29 2	2006	5:15 A
Examine	r	4a. Facility Name (If not institution, give CROFTON NURSING					ation of Death		4c. Count		
Funeral		5. Social Security Number 6. Se		. last birthday)	If Under	FTON 1 Year If U	Inder 24 Hrs.	8. Date of Birth	ANNE	ARUND	
Director			□M 2⊠F 74	Yrs.	Months		ours Min.	(Month, Day, SEPT. 3		SOUTH	CAROLIN
/land	-	10a. State 10b. County	10c. C	ity, Town or Lo	calion					100	I. Inside City Limit
death with the Maryland ma 23a or 28s-f show matternatified at	202	MD PRINCE (GEORGE'S I	UPPER M	ARLBO	RO					1 XYes 2 N
after death with the Mar r fema 23a or 28a-f s rinar mast be notified	E E	10e. Street and Number			10f. Zip			10	og. Citizen of		/?
a 23g	<u>a</u>	3908 BISHOP MILL			207				U.S	.A.	
item item		11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 📆 No	J.S. 13. V	Was Decede f Yes, speci	ent of Hispan ify Cuban, Me	ic Origin? (Spe exican, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	e - American ck, White, etc	Indian,
hours after ural; or ite	ò	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	XNo Sp	ecify:		Specif	AFRIC	AN AMERI
ed within 72 hours a ygiene. ygiene. ner then "natural", c. tt, the Medical Exant, the Medical Exant.	_ 	15. Decedent's Ed	ucation	16a. Deced	lent's Usual	Occupation			6b. Kind of B		
Med "n	be	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work DO NOT use	k done during e retired)	most of work	ng	00. 14.110 01 0	001110039111003	sti y
giene giene er the	E	9th	College (17401 34)	PRESS	ER				PRIVAT	E	
tal Hy doth of oth	ນ	17. Father's Name (First, Middle, Last)						(First, Middle, M	faiden Suman	ne)	
Ment Ment arked arked	2	JESSE HICKLIN						OLE			
permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important if Item 27 is marked other then "natural; or itema 23a or any injury or other treumatic event, the Medical Exercities must be once. To Be Completed by Funeral Di		19a. Informant's Name/Relationship (T) JESSIE LITTLEJOHN		19b. Mailin 3908	g Address	(Street and N	umber or Rura	UPPER M	City or Town,	State, Zip Co	LAND 20
Heall Heall tem 2 other	2	20a. Method of Disposition		Place of Dispos					Oc. Location -		
ages int of t: if if		1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cemetery, cren	natory or oth	her place)					
artme orden injung		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	u/		Management	4.4.4	u/k	. B. JEN	ANDOVE	R,MARY	LAND
Dermi Depa Impo any ir	1	21. Signature of Puneral Service Licens		//		Address of F		LANDOVER			20785
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Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	FATAL CA Due to (or as a consec	RDIAC A						In	oproximate terval Between nset and Death
Examiner		Sequentially list conditions.	b. Failure		ive						
executed an and rial-transit Examiner		Sequentially list conditions, if any, leading to immediate cases. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):							
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atten for u	1	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3 🗌	Ectopic pre				23d. Dat Mor	e of delivery oth Da	y Year
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cete has been s page 2 should											
The law requires mat the sets has been signed by the page 2 should be detache.	-							24a. Was an autopsy	24b. V	Vere autopsy prior to compli	findings availab etion of cause of
		Nr. Manager						perform	No 1	Yes 2] No
<u>5</u> 9 9 0		25. Was case referred to medical examiner?	Hospital:					Check only one			
his d	1	1 Yes 2 No 7. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of		44	Nursing Hon	ne 5 ☐ Residen	ce 6 □Othe	or (Specify)	
E = E =		Natural 5 Pending	(Month, Day Year)	Injury	M 200	c. Injury at Work? 1 ☐ Yes		8d. Describe how	injury occurr	∍ď	
After the funeral fune		3 ☐ Suicide 6 ☐ Could n x t e	28e. Place of Injury - At ho	ome farm stre				8f. Location (Stre	at and Numbe	or Divisi De	•
Attending Pt death. ctor: After th y the funeral floation:		4 Homicide determined	building, etc. (Specif	y)	et, ractory, t	onice		City or Town,	State)	or Hurai Ho	oute Number,
or Attending ter death. irector: After by the funer tiflcation			einian: To the heat of my kee	wledge, death	occurred at	the time, dat	e and place, a	nd due to the cau	se(s) and mar	nner as state	
or Attending ter death. irector: Atten by the fune rtiflcation		29a. Certifier 1 ☐ Certifying Physical Care only one)	ner: On the basis of examina	tion and/or inve	estigation, in	ii iiiy opiiiioii,		a at the time, date	e and place, a	nd due to the	cause(s)
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in a Hospitel or Attending hin 24 hours after death the Funerel Director: After holetely filled in by the fune Aedical Certification	2	one)	ner: On the basis of examina	tion and/or inve	estigation, in				e and place, a	nd due to the	cause(s)
or Attending ter death. irector: After by the funer tiflcation	2	9b. Signature and title of certifier	and manner stated.		29c. I				e and place, a	nd due to the	cause(s)
ter death. irector: After a by the fune	2	9b. Signature and title of certifier O. Name and address of person who co	and manner stated.	1 23a) (Type, P LY AVEN	29c. (License numb	Der 02	28	e and place, a	nd due to the	cause(s)

/ Department of Health and Mental Hygiene	1	7	n	
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Loue $ \omega \omega \omega$ Little Baltimore, Maryland 21215-0036	

	1 - State Registrar			rtment of H		F	Reg. No.	16 40492		
cian lical	Decedent's Name (First, Middle, Last, Louella Mae LITTL	E				2. Date of Dea	Day	Year 2521		
iner	4a. Fecility Name (If not institution, give Control Co	ly Nursing	tome	4b. City, Town, or 15 Under 1 Year	S boro If Under 24 Hrs.	8. Date of Birt	h	of Death N O O 9. Bitthplace (State or Foreig		
	214-09-0826	M 212 F 103	Yrs.	Months Days	Hours Min.	Dec. 18	v. Yearl	Country) Maryland		
	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limi		
Director	Maryland Washin	gton	Hager					1 □ Yes 2 🛣 N		
Dire	10e. Street and Number 13534 Spriggs Roa	d		10f. Zip Code 2174	0		10g. Citizen of V USA	Vhat Country?		
y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	l I	Vas Decedent of Hi Yes, specify Cuba		ecify Yes or No- Rican, etc.)		e - American Indian, k, White, etc.		
Completed by	3 ☐ Widowed 4 🛣 Divorced 15. Decedent's Edu (Specify only highest grade)	cation e completed)		ent's Usual Occupa kind of work done of OO NOT use retired,		ing		Specify: white Sb. Kind of Business/Industry		
dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		itress			departm	ent store		
Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumam			
2	Thomas Martin Shiv					Kathryn				
17	19a. Informant's Name/Relationship (Ty Jane Potts - niec			g Address <i>(Street a</i> Edgewood				State, Zip Code) m., Md. 21740		
	20a. Method of Disposition	20b.		sition (Name of natory or other place		Date Tale		City or Town, State		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	idinoval ilolli State		s Epis.Ch		/8/06	Hancock	, Maryland		
	21. Signature of Funeral Service License	99	12	The and Addres	s of Facility M	INNICH I	FUNERAL			
	23a. Part1. Enter the disease, or compli	(1) /1 /U	my 1	E. Wils	on Blvd.	, Hagers	stown, M	aryland 21740		
	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	quence of):					Interval Between Onset and Death		
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mor	o of delivery th Day Year		
b	Part II. Other significant conditions con	ntributing to death but not re	sulting in the un	derlying cause give	n in Part I.			bute to the cause of death? 3 ☐ Probably 4 Swinknow		
Completed						24a. Was a autops perform	med? d	/ere autopsy findings available for to completion of cause of eath? ☐ Yes 2 ☐ No		
Be	25. Was case referred to medical examiner?	lospital:		Otho	26. Place of Deatl					
1; To	1 Yes 2 No	1 ☐ Inpatient 2 ☐	ER/Outpatient 28b. Time of		4 Y Nuising no		ence 6 Othe			
Certification;	1 [®] ¶Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury		es 2 No					
Certif	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	et, ractory, office		City or Tow	n, State)	r or Rural Route Number,		
edical	29a. Certifier 1 ★ Certifying Phys (Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occurr	and due to the c ed at the time, d	ause(s) and mar late and place, a	ner as stated. nd due to the cause(s)		
Σ	29b. Signature and title of certifier			29c. License				d. Date signed (Month, Day, Year)		
-		3		no	2323	1	15/21	,		

Registrar

			For State Registrar	State of Ma	ıryland	-	artment of H ctificate of I		Mental H	ygiene Reg. No	0000	11119	
l	Physicia /Medic		1. Decedent's Name (First, Middle, L Michael		rdon		Leslie		2. Date of D Month DECEMB	eath Day	y Year	3. Time of Death 8:16 A ^M	
	Examin Funeral Director		4a. Facility Name (If not institution, g MEMORIAL HOSPITA 5. Social Security Number 228-62-5642	L		s <i>t birthday)</i> Yrs.	4b. City, Town, or CUMBERLA If Under 1 Year Months Days		ath	irth	County of Death ALLEGANY 9. Birthp County	olace (State or Foreign	
	FILE A LATER 13-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	or	Usual Residence of Decedent 10a. State PA Bedf	ord	10c. City,	Town or Lo	cation earville		03722	, , , , ,		10d. Inside City Limits 1 □ Yes 2 ☒ No	
		Funeral Director	10e. Street and Number 210 Beans Con				10f. Zip Code	5535		10g. Cit	10g. Citizen of What Country?		
20		by Funera	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?	o 196	8	Was Decedent of H f Yes, specify Cuba 1 □ Yes 2ሺ No		(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - Americ Black, White,	etc.	
00-617		Completed t	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education	197	16a. Deced (Give life. L	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of w	vorking		ind of Business/In	•	
and z		Be	12 17. Father's Name (<i>First, Middle, La</i> John	st) Herbert			Security		ame (First, Middl	e, Maiden	ŕ		
ıldı yıd	12 should and Men Is marke	2	19a. Informant's Name/Relationship Candy C. Leslie	(Type. Print)			g Address (Street a		Rural Route Num		or Town, State, Zip		
nore, i	Pages 1 and ent of Healtl nt; If item 27 y or other t		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	20b. Pla ce MD V	ace of Dispo metery, crer	sition (Name of natory or other place	re)	Date	20c. Lo	, PA 155 ocation - City or To Flintsto	own, State	
Dallino	permit. P Departm Importar any injui	30 3	21. Signature Funeral Service Lic		۷ طنا	22		ss of Facility	dams Far	nily	Funeral	Home, P.A. 21502	
	Physician /Medical	67. Y	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDI Due to (or as a	e. AL IN	FARCT		g, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death 5 MINUTES	
,	physician and physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c									UNKNOWN	
02 00 00	certificate be ding physicia se as the bur	edical	IF FEMALE:	d	of pregnan	rov.							
	The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal o	death 3□	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ery Day Year	
cords, r	equires tha en signed ould be det	þ	Part II. Other significant conditions DTABETES	s contributing to death bu	t not result	ting in the ur	nderlying cause give	en in Part I.			use contribute to to	he cause of death?	
ב ב	:: The law i icate has be r, page 2 sh	Completed	DIABETIC RENAL F	'AILURE					24a. Wa - aut per 1∐ Yes	opsy formed/?	prior to co death?	opsy findings available mpletion of cause of 2 No	
in or vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2.	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 27 No 27. Manner of Death 1 X Natural 5 ☐ Pending	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day	y 1	R/Outpatien 28b. Time of Injury	28c. Injur Worl	er: 4□ Nursing y at √?	Home 5 Res	sidence	6 ☐Other (Specifing occurred		
DIVISION	al or Attending s after death. al Director: After ed in by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 280 Place of inju	ry - At hon . (Specify)	ne, farm, str		Yes 2 ☐ No	28f. Location City or To	(Street an own, State	nd Number or Rura e)	al Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination	fledge, death on and/or in	vestigation, in my o	pinion, death oc	ice, and due to the courred at the time	e cause(s) e, date and) and manner as s d place, and due t	tated. o the cause(s)	
	1Kg-3	M	29b. Signature and oftle of certifier	or al	Jan Jan	7	29c. License	81875			te signed (Month, MBER / ,	2006	
	×		30. Name and address of person who DR. ROBERT WELIK	, 904 SETON	DRIV	E, CU		, MD	21502				
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 4	32. Registra	ii s siynatt	J.	Cock						

06-08683		_		Please 1	ype or	Print	in Blac	k Ind	elible Ink				
/irginia May Lawre	1	For State Ame	Si ended #4	tate of Maryland	г <i>т</i> Бера <i>Сег</i>	artmei <i>rtificat</i>	nt of Hea e of Dea	aith ar a <i>th</i>	nd Mental I	Hygiene	Dog No	200	6 1,01,9
Physician/ Medical Examine		tegistrar 11/ 1 Decedent's Nam VIRGIN	e (First, Midd	Allegany Count de,Last) IAY LAWRE						2. Date of D Month Novemb	Day	Year	3. Time of Death 1940 hrs
The .	Í	4a. Facility Name (721 Gepha		on, give street and number 721 Gephart				, Town, o nberlar	r Location of Dea nd	th		c. County of Deat Allegany	h
Funeral	1	5. Social Security I			ge (In yrs. I	ast birthd	··	nder 1 Ye		_		/DD/YYYY) 9. 8i Forei	
Director		220-32-		1 M 2X F	85		Yrs. Mon	iths Da	ys Hours M	03/22	/192		ountry) WV
any	_	Usual Residence o 10a. State	10b. County		10c. City,	Town or	Location						10d Inside City Limits
ne Maryland or 28a-f show any ffed at once.	<u>.</u>	MD		EGANY	RA	AMLI					40.00		1 Yes 2 X No
the Maryland a or 28a-f sh tified at onc		10e. Street and Nu		LEN HIGHW	ΑY		101. 2	ip Code 215	57			izen of What Cou $J ullet S ullet A ullet$	intry?
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland to fleatth and Mental Hygene t: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traunnatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		11 Marital Status		12. Was Decede	nt Ever in U.	.S. 1			ispanic Origin? (No-	14. Race - Ame White, etc.	rican Indian, 8lack,
ter deat ", or ite er must	- [Never Marri Widowed		Idiliou	2 X No				o specify:				WHITE
iours aft natural" xamine	֓֞֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝	15. Decedent's E	ducation (Spe	Lor Dates: ecify only highest grade co			cedent's Usua	al Occup	ation (Give kind o		16b.	Kind of Business	
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	אבור	Elementary/Sec	ondary (0-12)	College (1-4 o	r 5+)		JIPMEN.		rerilize			HOSPITA	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name				~			18. Mother's Nan			•	
ould be fill out out out out out out out out out out		OSBURN 19a. Informant's Na	the first formation	OKIN ship (Type, Print)		19b. I	Mailing Addre	ss (Stre	TINY eet and Number o	SPON Rural Route N	A-1	Eity or Town, State	e. Zip Code)
MD and 2 shot alth and 37 is a sumatic		DONALI	LAWI			G.	537 E	3 St	reet, I	LaVale	, MI	2150	2
Baltimore, MD : permit Pages 1 and 2 should permit Pages 1 and 2 should be partment of Health and Important: If item 27 is: injury or other traumatic		20a. Method of Dis 1 X Burial 2		n 3 Removal from	State	crematory	Disposition (N y or other place	ce)		Date /1.0./2004		Location - City o	
Baltimore, permit Pages I ar Department of He Important: If ite injury or other tr	ŀ	4 Donation 5	Other S		RES	TLAW			DENS 11/			LAVALE,	
Balti permit Departn Importi injury	1	Okeno	VA).	Upchure	"L	8	202	GRE	ENE STRE	ET, CUM	BERI.	AND, MD	21502
Physician /Medical	1	failure. List or	nly one cause	A4b				e of dying	g, such as cardiac	or respiratory a	arrest, sh	ock, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause or condition resulti		Due to (or as a cor			Disease						
1		Sequentially list co	nmediate	b. Due to (or as a cor	sequence o	ıf):							
ted		cause. Enter Unde (Disease or injury) events resulting in	that initiated	c. Due to (or as a cor	sequence o	ıf):							9
an and all - transit	<u> </u>			d.									
so, te be ex sysician burial	ב ב ב	UNPENDED	1	AMENDED	ome of pred	nancy					23	d Date of deliver	<u></u>
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit addical Certification: To Be Completed by Physician/Medical Expedical Certification:	2 Clairin	3b. Was decedent past 12 month:	s?	4 Pregnant at time of death 5 Other (Specify)						Month Day Year			
P.O. B. that the de detached for Phy.		Part II. Other sign			ath but not r	esulting i	n the underlyi	ng cause	given in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?
S, P.O. uires that the n signed by 1 d be detached by P.O.	2	Asthma; D	iabetes M	ellitus									bably 4 Unknown
of Vital Pecords, ling Physician: The law requires After this certif care has been significated in the 2 should be remained in the Benefield of the 1 should be completed.											topsy formed?	prior to death?	utopsy findings available completion of cause of
ant The ertification part	וע	25. Was case refer	rred to medic					26.Plac	ce of Death (Chec		s Z[_]	10 1 V	es 2 No
F Vita Physicis or this ce ral direc	2 L	examiner? 1 ✓ Yes 27. Manner of Dea	2 No	Hospital: 1 Inpa	tient 2		ne of Injury	DOA	Other Nurs	ing Home 5		ence 6 Othe	er: Scene
ON O ath. or: Afte he fune		1 V Natural	5 Per	(Month, Day	(Year)	200. (1)	ne or anjury	1 _	Yes 2 No	20d. Describ	e now m	dry occurred	
Division o Division o To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	e III Ca	2 Accident 3 Suicide 4 Homicide	6 Cou	28e. Place of 28e. Place of (Specify)	Injury - At h	ome, fam	n, street, facto	ory, office	building, etc.	28f, Location or Town		and Number or R	ural Route Number, City
To the Hosp within 24 hc To the Funcompletely I		29a. Certifier 1 (Check only one)		Physician: To the best of aminer:On the basis of ex	amination a								
To with To com	N P	29b. Signature and	title of certif	and manner state	d		2	29c. Licer	se number		29d.	Date signed (Mo	onth, Day, Year)
		116	Mor	lewy)				0.0	.M.E.		No	vember 15, 2	006
UL,0		30. Name and add Laron Lock	111	n who completed suse o Assist <mark>ant Medical</mark> E			Penn Stree	et, Balt	imore, MD 21	201			
Stat	е	31. Date filed (Mor	The Day Year	2006 32. Pegist	rar's Signati	ure	Coarts	,					

DHMH 17 Rev 1/2001 OCME 2006

		1 - For State Registrar	State of Marylar	nd / Depa		lealth and M	Mental Hyg	9			
	Physician /Medical	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give	NAOMI LITOF	'F	Ah City Toyen o	r Location of Death	2. Date of Deat Month DECEMBE	Day Ye	10:00 A M		
1.2	Examiner	HEBREW HOME OF GRE 5. Social Security Number 6. Se	EATER WASHINGT			ROCKVILLE If Under 24 Hrs.		МС	ONTGOMERY		
(A) (A)	Funeral Director			3 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 02/01/19	9. 913	Birthplace (State or Foreign Country) POLAND		
	Maryland fast at tor	10a. State 10b. County MARYLAND MONT	GOMERY 10c. Ci	ity, Town or Lo	ROCKVI	LLE			10d. Inside City Limits 1 X Yes 2 ☐ No		
į	with the Mar 3a or 28a-f st it to recitified if Director	10e. Street and Number 6111 MONTROSE ROAD	APT514		10f. Zip Code	0852	10	og. Citizen of Wha	·		
036	should be filed within 72 hours after death with the Maryland Mental Hygiene. Marked other than "naturel", or Itama 23a or 28a-f show marked other than "naturel", or Itama 23a or 28a-f show imatic event, the Medical Examiner must be recitified at Index of the Medical Examiner must be recitified at Index of the Medical Examiner must be recitified at Index of the Medical Examiner must be recitified at Index of the Medical Examiner Medical Examin	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	Decedent Ever in U.S. d Forces? de 2 (2M) o			ecify Yes or No- Rican, etc.)	14. Race - /	J.S.A. ce - American Indian, ck, White, etc. fy: WHITE		
215-0(ed within 72 ho ygiene. ner then "nature t, I'm Medical Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Give I	ent's Usual Occup kind of work done OO NOT use retired	ing	6b. Kind of Busin	ess/Industry			
77	at Hygi Tother vent, I	12 17. Father's Name (First, Middle, Last) ABRAHAM BORAK			MERCH		e (First, Middle, M		GROCER		
	alth al	19a. Informant's Name/Relationship (7 HARRIET D. KRAKOW/	DAUGHTER	3458 C	HISWICK	and Number or Rui	ER SPRING		., .,		
altimore,	permit. Pages 1 a Department of He Important: If Item eny injury or othe	20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Departion 5 □ Other (Specify	nemoval mom State		sition (Name of latory or other place MEML GD			Oc. Location - City	rorTown, State RCH, VIRGINIA		
760,	ule be executed vysician and ne burial-transit ne burial-transit cal Examiner	23a. Pantl. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	elications that caused the deal	th. Do not enter A G E quence of):	191 ROCKV or the mode of dyin	GEST	C. ROCKVI or respiratory arre	LLE, MAR St. HEARI	YLAND 20852 Approximate Interval Between Onset and Death		
5 X	es that the death certificationed by the attending phy be detached for use as the by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	al death 3 🗍	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year		
rds, P		Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying cause giv	en in Part I.		_	e to the cause of death? Probably 4 Unknown		
	the last page 2						24a. Was an autopsy perform	ed2 prior death	autopsy findings available to completion of cause of 1? Yes 2 No		
No	rhis certificatel director,	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpations	3 DOA Oth		Check only one	nce 6 🗆 Other (5			
	Attending Pri) r death. actor: After thi by the funeral of	27. Mann eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		28d. Describe how		рвсту)		
i i	e nospitel of Atlenting P 4 hours after death. • Funerel Director: After t letely filled in by the funers dical Certification:	3 Suicide 6 Could not be determined	building, etc. (Special	(y)			City or Town,	State)	Rural Route Number,		
4	5 5 5 E	one) 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inve	estigation, in my of	pinion, death occur	ed at the time, dat	te and place, and	due to the cause(s)		
	Con Site	29b. Signature and title of certifier	MD		29c. License	00610		d. Date signed (M	onth, Day, Year)		
	1	30. Name and address of person who could be supported by SHA GOL	LAPALLI	, 61.		PNTROS	E Ro	AD RO	CHEVILLE		
	State Registrar	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	april 1			1,17			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30, Month Clark R. Mallder 2006 November 9:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 162 East Bay View Drive Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XX X 2 □ F Yrs 326-20-5152 Dec 24, 1928 Illinois Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ Yes 211 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 162 East Bay View Drive 21403 United States 12. Was Decedent Ever in U.S. Adjusted Forces? 1 △ Mas 2 □ No 194 If Yes, Give Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1945· 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🕅 Xio White Specify: Specify: XIX Widowed 4 □ Divorced 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Diver U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clark A. Mallder Lucille Maurer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clark D. Mallder 300 West Hickory Bend Enterprise AL 36330 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. 12/28/2006 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical **Examiner**

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Leath and Mental Hygiene.

To is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed burial-trar the attending ph ed by the a signed k page 2 s this

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

within 2. ٥

Examine Physician/Medical 2 Completed funeral director Be n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fu

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23	ld. Date of delivery Month Day Year				
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco ase	e contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown		
			24a. Was an autopsy performed? 1 Yes	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Other: 4 Nursing	Home 5 Residence 6	□Other (Specify)		
27. Manner of Death 1	(,,	me of ury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury			
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		n, street, factory, office	28f. Location (Street and City or Town, State)	Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best of my knowledge, xaminer: On the basis of examination and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the cause(s) a curred at the time, date and p	and manner as stated. blace, and due to the cause(s)		
29b. Signature and title of certifier		29c. License number	29d. Date	signed (Month, Day, Year)		
> Im	elle	~ D08194	11/30	0/2006		
30. Name and andress of person w	ho completed cause of death (Item 23a) (T	ype, Print)				
Tack R Lichenst	ein M.D. 205 Rido	ely Avenue Annano	lie Maryland	21401		

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

DEC 0 4 2006

Please Type or Print in Black Indelible Ink

arnecia Morris	1	State of Maryland /		ent of Health and ate of Death	и мента пу		No. 200	c i. n. n.
Physicia		egistrar/meno#10e_PentHPGC 12-4-06cr . Decedent's Name (First, Middle,Last)		, <u>D</u>		Reg 2. Date of Death Month	1-1-	3 Time of Death
Medical Examir	er	DARNECIA L. MORI	RIS	La ou z	I to a of Death	Month D November 2	5, 2006 4c. County of Deat	2345 hrs
- A		la Facility Name (if not institution, give street and number) Southern Maryland Hospital		4b City, Town, or Clinton	Location of Death		Prince Georg	
Funeral Director		5. Social Security Number	(In yrs. last birth	Months Days		8 Date of Birth (I	MM/DD/YYYY) 9. Bi 1952 Forei Co	rtbplace (State or gNOT th buntry) Carolin
ow any		Jsual Residence of Decedent 10a. State 10b. County D • C •	10c City, Town o Wash	or Location nington				10d Inside City Limits
he Maryland 1 or 28a-f show any iffed at once,	Director	10e. Street and Number 517 46th Street, S.E.	Washi	10f. Zip Code 20	019	10g.	Citizen of What Cou	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene taut: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	Widowed 4 Divorced If Yes, Give Year or Dates:	X No	13. Was Decedent of His If Yes, specify Cubar	specify:	Rican, etc.)	White, etc. Specify:	rican Indian, Black,
36 in 72 hours han "natur dical Exami	Completed t	15 Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5 12th Grade	<u>i+\</u>	Decedent's Usual Occupat during most of working life Administrative	. DO NOT use retir	ed)	6b Kind of Business Chinistrati	
215-00; te filed with tal Hygiene ked other ti nt, the Mec	Be Com	17. Father's Name (First, Middle, Last) Clarence Peoples			18.Mother's Name Beaula	(First, Middle, Mai h Morri		
MD 21.	힏	19a Informant's Name/Relationship (Type, Print) Beaulah Morris (Mothe	r) 5	. Mailing Address (Street 17 46th St	reet, S	E. Wa	shinato	e, Zip Code) n , D . C . 20019 r Town, State
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	ite cremate	of Disposition (Name of cellory or other place) y Memorial Park 22. Name and Address	Decemb	er 7, 2006 Lins Fu	Landover, ineral H	Maryland ome, Inc.
ற ஆக் உள் Physician /Medical		23a Part I. Enter the disease, or complications that caused failure. List only one cause on each line.						Approximate 2 1 1 Between Onset and Death
Examiner	İ	Immediate Cause (Final disease or condition resulting in death) Mesenteric Isch Due to (or as a conse						
bounded	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated least sequentially larger.)	equence of):	sis				
uted Id ransit		events resulting in death) Last Due to (or as a conse	equence or).					
e exectician an	Medical	UNPENDED AMENDED						
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	2	Fetal death 3 Other (Specify)	Ectopic pregna	ncy	23d. Date of delive Month	ny Day Year
P.O. Be res that the de signed by the be detached is	ρ	Part II. Other significant conditions contributing to death	n but not resulting	g in the underlying cause	given in Part I			o the cause of death?
Division of Vital Records, tal or Attending Physician: The law requir is after death all Director: After this certificate has been seled in by the funeral director, page 2 should!	Completed		-			24a Was an autopsy perform 1 ✓ Yes 2	prior to death?	
an: Ti	a	25. Was case referred to medical		26 Place	e of Death (Check	only one)		
of Vitaing Physici After this c	To B	1 V Yes Z No		outpatient 3 DOA Time of Injury 28c Inju	Other Nursin	g Home 5 Re	esidence 6 Oth	er
in of ading I th :: Afte e funer	ion:	27. Manner of Death 1 ✓ Natural 5 Pending 28a. Date of Inju (Month, Day, V	(ear)		Yes 2 No	200 3000100110	ir injury cocumou	
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ajury - At home, fa	arm, street, factory, office	building, etc.	28f. Location (Str or Town, Sta		Rural Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical C	29a. Certifier (Check only) 2 Medical Examiner: On the basis of examiner and manner stated	y knowledge, de mination and/or i	eath occurred at the time, dinvestigation, in my opinion	n, death occurred a	it the time, date an	s) and manner as stand place, and due to 29d. Date signed (M	the cause(s)
	2	29b Signature and title of Certifier Or Company of the second of the se	Heath (Ham 22c)		.M.E.		November 26, 2	
		30. Name and address of person who complet use of a Laron Locke MD. Assistant Medical Ex		1 Penn Street, Balti	more, MD 212	01		
S	tate		ar's Signature	d				
Regis	trar	DEC 0 4 2006 Faceur	D. Opt					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MORELAND 3:08 PM LUANTTA OROTHY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Days Months 1 ☐ M 2 🖾 F 54 1952 050-46-0959 June 1, Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Germantown Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20874 18504 Mateny Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer 12 Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Ellis Charles Moreland Sr. Nina Overton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shawn B. Rabsatt / Son 18504 Mateny Road, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 12/06/2006 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part / Enter the disease or complications that caused the shock or heart failure, list only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) lans Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

Physician /Medical **Examiner**

attending physician death certificate be

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r

altimore, Maryland 21215-0036

Box 68760

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Records,

Division or Vital

Director

Funeral

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Completed

Be

burial-transit 38

Examine Physician/Medical the for use ģ signed k þ Completed Be After this funeral c To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification:

25. Was case referred to medical examiner?

27. Manner of Death Natural Natural 2 Accident

29a. Certifier (Check only one)

5 Pending investigation 3 Suicide 4 ☐ Homicide

6 ☐ Could not be determined

Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Nidhi Singh Nikhanj, M.D.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

9b.	Signature	and	title	of	certifie

29c. License number 20064560

ROCKUNIE, MO

29d. Date signed (Month, Day, Year)

State Registrar

MEDICAL 31. Date filed (Month, Day, Year) DEC -

DRIVE ENTER

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

2294 Jeffearn

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

Richard Keller Newcomer

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

of 24 hours the Funeral Directory within 2 To the I

ORIGINAL

29c. License number

BUND SMITHSBURGH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

Lecember

Year

2004

Washington

U.S.A

14. Bace - American Indian Black, White, etc.

Aircraft

Smithsburg, Md.

23d. Date of delivery

2 No 3 Probably

29d. Date signed (Month, Day, Year) 12-12-06

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 400

Year

Month

Specify:

Birthplace (State or Foreign Country)

White

21783

Approximate Interval Between Onset and Death

10d. Inside City Limits

1 ☐ Yes 2 XNo

Maryland

4c. County of Death

n State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certific

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** $P^{\,\mathsf{M}}$ Nizza 28,2006 Pasquale November 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) May 22,1928 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 78 Director 007-22-3875 Maine Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes 2 X No Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9500 Glen Wav 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1945-1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify \$ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Meteorologist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Nizza Alphonse Emma Johnson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Nizza - Wife 9500 Glen Way, Ft. Washington, MD 20744 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Arlington National Dec.18,2006 | Arlington, Virginia 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service License George de Kalasfuneral Home, P.A. ale 61<u>60 Oxon Hill Rd.,Oxon Hill, Md 20745</u> 23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 17c /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-tran and P.O. Box 68760. physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Other: 4 Nursing Home Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA 1 hpatient 5 ☐ Residence 6 ☐ Other (Specify) After this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 ☐ Pending investigation Injury thours after death.

Funeral Director: Af
ely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100060920 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PISCATAWAY ROAD \$= 240 TUONNE RUDDER 32. Registrar's Signature State Registrar